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CRITICAL ANALYSIS OF THE ELEMENTS OF PSYCHIC FUNCTIONS

Part I

BY CARL M. HEROLD (NEW YORK)

CHAPTER I

In the 'heroic' phase of psychoanalysis when the discovery of new facts was at its peak, descriptions and formulations were obtained by facile adaptation of terms and concepts borrowed from various, sometimes very distant fields. In his paper, On Narcissism: An Introduction (1914), Freud defended this laxity of strict logical definition. Rejecting a logical clarification of the concepts he was using, he preferred a not very circumscribed, even vague presentation of his observations. He left, without regret, the logical fundamentals to speculation, hoping that the development of psychoanalytic science would lead to further factual clarification of his concepts. He held to the belief that honest observation of facts is preferable to a well-rounded speculative theory which is not the foundation, but the superstructure of a science, easily removable and replaceable by another.

We still believe that the observation of facts is the most important factor in building a science, considering that it provides the material from which the structure of the science is erected. But in the concepts which we use in describing observed facts may lie the germ of new observations if our concepts are true representations of the facts. We cannot recognize things, if we are not intellectually prepared to look for them. But if there is something awry in the formulation of an observation, then in this formulation lies the germ of a subsequent misinterpretation of newly observed facts.

Without denying that some of the clarification of ideas which Freud expected from the development of psychoanalysis has been accomplished, parallel with the clarification of many

concepts runs an obscuration of some others. For example, in a meeting of a psychoanalytic society a short time ago, there was a very deplorable disagreement about a term which for all psychologists should be one of the clearest concepts: the ego. 'Ego', 'self', 'personality' were used in quite confused fashion.

There is perhaps the least confusion about the concept. superego. This is very interesting because a very similar concept, the categorical imperative, was the only thing which Immanuel Kant detected when he looked into his own personality. It seems easiest for us to conceive of ourselves as moral beings. Freud, whom one could least reproach for not having seen the less attractive side of human nature, defined the superego more clearly than many others of his concepts. Terms like id, narcissism, have comparatively loose definitions. The meaning of the cornerstone of all psychoanalytic thinking, the unconscious, is undeniably clear, but its definition is a negative one because it means all that is not permitted or able to become conscious. But how things become conscious is also not clearly defined, although it is very definite as far as it is empirically experienced. Many psychoanalytic terms are derived exclusively from empirical evidence. As long as its theoretical structure did not become too complicated, as long as it tried merely to cover the grossest fundamental facts, this empirical character of psychoanalytic terminology served its purpose very well. But beyond a certain point, the empirical evidence on which this terminology was based became more and more remote from the terms used. New meanings were injected into these empirical terms which were not originally in them. In a personal discussion with Freud, he expressed his astonishment that so many analysts use terms like id, ego, superego, as if they were real entities and not merely auxiliary representations.

It is time that critical attention be turned to that empirical evidence on which so many psychoanalytic and psychological terms are based. As Kant investigated the fundamental principles of reasoning to correct the misuse of reason, in a similar

critical manner the preconditions under which all psychological material is experienced and recognized should be investigated.[1]

In his Critique of Pure Reason, Kant discussed a point which pertains directly to our problem. Trying to understand how knowledge is possible in principle, he first undertook to discuss critically the foundations of intuition *(Anschauung)*. In that part of his philosophy which he called Transcendental Æsthetics, he found that after eliminating from intuition all empirical content, there remained two qualities which could not be eliminated without making intuition altogether impossible. These two qualities were space and time.

Space and time remain after eliminating all empirical data conveyed to us by the empirical stimulation of our senses by empirical objects. Abstract from all empirical objects, all shape, color, temperature, sound—all the effects of sensibility—and there still remain space and time. Kant distinguished an external and internal intuition, and found that space is related to external, time to internal intuition. This means that man perceives himself in the form of time, and perceives external objects in the form of space.

There are philosophies which distrust the impressions of the senses, and therefore take the stand that the quality of reality which naïve reason attributes to the content of intuition is partly or altogether unjustifiable. This philosophical attitude is called 'idealism'. There are different schools of idealistic philosophy. Berkeley is the representative of one school which Kant called 'dogmatic idealism'. His reasoning, as Kant reviews it, may be summed up as follows: all that we note of objects is spatial; space is, by itself, impossible; therefore all objects are—like space—pure imagination.

It was easy for Kant to prove that this argument is false. His contention that space is not a property of objects, but a

[1] There are many investigations of psychologists and philosophers which are deserving of being quoted here, but they lack, in general, relevance to psychoanalytic observations and methods, and as this paper is addressed chiefly to psychoanalysts, a review of the academic psychological schools would confuse rather than clarify.

form of intuition, is the cornerstone of his argument. If space were a property of things, dogmatic idealism would be unavoidable. Space, a nonentity, belonging to objects would prove the objects also to be nonentities. Space being a property of intuition, in other words, a subjective condition under which intuition of things functions, the status of space as a nonentity has no bearing whatsoever on objects which merely *appear* to be in space.

It was harder for Kant to deal with what he called 'problematical idealism' of Descartes. This great philosopher believed that dogmatic idealism which deprives all consciousness of reality could not be right because, he found, there is some content of consciousness which has an immediate quality of reality, lacking in all other contents of consciousness. That content is the experience of our own existence. The only empirical assertion which was of undoubted certainty and realism for Descartes was the sentence, 'I am'. This, he said, is the only immediate experience possible. Compared with the realism of the perception of one's own existence, the reality of all other perceptions becomes problematical.

Kant holds that problematical idealism is truly scientific in principle and stands as long as there is no further proof that we have real experience of external things as well, and not merely fancies of them. For this purpose it has to be proved that the subjective experience of the 'I am' is in itself only possible under the assumption of indubitable experience of objects.

Kant offers to prove the theorem that the simple consciousness of our own existence proves the existence of external objects in space. Because time is the form of the internal sense, of the intuition of one's self, it is to be concluded that one is conscious of his own existence as determined in time. Kant argues that all determination in regard to time presupposes the existence of something permanent in perception. This permanent something cannot be within us, he says, because our own temporal existence is itself determined by this permanent something. The determination of a thing by

something in itself cannot be logically accepted. The perception of this permanent something, therefore, must be possible only through a thing outside one's self, an external reality. The intuition of real things outside of self, as determined by space, is the condition of any determination in time, and therefore of becoming conscious of that which is exclusively determined by time (self).

This whole question boils down to the fact that the inner sense cannot work without the outer sense. The outer sense giving us a spatial intuition of objects thus making it possible for us to conceive intuitively of ourselves as being determined in time.

Kant distinguishes between consciousness of our own existence and determination of our own existence in time. Only the latter, he says, is made possible by immediate intuition of external things in space. For Kant the ego, or what he understood by Descartes' 'I am', is merely an accompanying element in all experience. In other words, the ego is merely the mental representation of the identity of the subject which experiences so many different objective things. This identity of the subject which accompanies all its experiences can be determined by time only.[2] It is the only unvaried factor in all our experiences and this invariability is, of course, a temporal quality. But in itself the fact that we are identical with ourselves in all our experiences adds nothing to our knowledge and is therefore no experience as Kant defines this term. We must not forget that Kant was speaking about pure reason, and that what he described as experience related only to the powers of reasoning. Of course, the fact that each person is identical with himself, that in all his experiences there is a subjective element which makes him speak of himself as 'I', is hardly deserving to be described as knowledge although it is a condition for acquiring knowledge. This 'I' is an objectified mental representation of that 'something permanent' in ourselves which is contained in every experience

[2] *Cf.* footnote [9], p. 527.

we have. It is the objective, rational, and grammatical representation of the experiencing subject.

This 'subject' is an object in reference to our reasoning intelligence. But to our feeling experience it is something which is the core of our being. As far as we do not reflect upon ourselves as subjects, as far as we merely sense and feel our own existence as a reality given to our sensory apparatus, we become aware of ourselves in quite a different sense. That awareness of ourselves lacks the objective quality which adheres to the awareness of knowledgeable objects. It is an exquisitely subjective way of experiencing ourselves. This awareness of ourselves lies beyond the scope of subject-object relationships, for which reason it cannot furnish directly any intelligible knowledge, as knowledge in its proper sense is based on the object-subject relationship as a necessary condition. But it is not merely knowledge which can be a content of our awareness. The subjective way to become aware of ourselves leads to a sensation or, if one prefers, a 'feeling' of ourselves which constitutes the content of that kind of awareness. By finding out the principles of that subjective experience of ourselves we will perhaps be able to get a secondary or indirect knowledge of the fundamental principles of self-experience, thus opening the way to a theory of subjective awareness in general.

CHAPTER II

As far as intuition is concerned, Kant is absolutely right in stating that our own existence which intuitively appears to us as determined in time, cannot derive its reality from something inside ourselves, but only from things outside of ourselves, that is, from external reality which appears to intuition as determined in space. And when Descartes states that the only absolutely certain existence which we experience is our own existence, compared with which the reality of other existences outside of ourselves is problematical, one could answer 'If a brick falls from a roof and hits you, you will not only be convinced of the reality of your own existence which

you experience immediately, but the reality of the brick's existence too will not remain problematical for you'.

Descartes might then defend himself by replying: 'It is true that something was proven to me; but the thing proven is merely that my body has the same problematical reality as the brick has, but not the fact that I get knowledge of the existence of the brick in the same way as I get knowledge of my own existence. You, Mr. Kant,' he would say, 'are trying to prove that only by the material existence of the thing outside of myself do I become aware of my existence. This certainly is not true, for I have only indirect knowledge of the brick as the cause of my pain. What I really experienced was merely pain, and not anything pertaining to the brick. My assumption that a brick must be real is only a conclusion which I draw from the fact that I felt pain.'

We come now to the very essence of the question of where the basis of the sense of reality lies. Obviously it does not lie in the field of intuition. The reality of the falling brick was based on the absolutely unintuitive sensation of pain. The connection between the pain and the external object which caused the pain was merely secondarily derived by means of intuition and reflection.

The immediate proof of reality must come from a different source and must lie there where Descartes suspected it to lie: inside of ourselves. But this immediate reality is not objective reality as conveyed to us by intuition. It must be another kind of perception which is the medium through which we become immediately aware of the reality of our own existence. This different kind of perception I propose to call pure sensibility. I call it pure, because its sensations are direct and immediate, and not mixed up with any of those elements of projection which lie in our faculty of intuition. In the example of the falling brick, I introduced the sensation of pain. In this example, the relation of pain to a pain-causing external object is predominant. But it is easy to find evidence that pain is not necessarily related to external objects. Pain, although real, is a subjective experience.

But now we will lay the question of pain aside and revert to Descartes and his thesis that the immediate consciousness of one's own existence is the basis of the sense of reality. Although he widened this thesis to the well-known *'cogito, ergo sum'*, and doing so departed from the very core of his original concept, we still believe that he had found something which Schopenhauer elaborated much more clearly.

Schopenhauer argued that for all our intuition and reflection, we are not different in principle from any external object. As far as our own existence is intelligible to us, it is 'appearance', a mere representation of ourselves in our mind. But, he said, we have another small entrance by which we can approach the 'thing in itself', which forever hides behind the appearance of things. We ourselves, are not only objects for our intuition, but are able to experience ourselves directly and immediately. More simply stated, he believed that intuition is not the only way to experience ourselves. It is true, if we only look at ourselves, we merely appear to ourselves, and we cannot have a glimpse of what we are for, and in ourselves. But seeing is not the only possible means of self-experience; we can feel ourselves. Abandoning all intuition, all means of measuring ourselves in time and space, we still can get an unintelligible but very definite experience of what we are. What Schopenhauer felt in himself, by means of what I have called pure sensibility, or, if you wish, pure feeling, was the 'will to live'.

Schopenhauer contended that through this small entrance accessible to the inner self, we can recognize the will to live, as the direct manifestation of the 'thing in itself'. Being too intent on breaking the barriers which Kant indisputably erected between man's insatiable curiosity and the reality beyond his experience, Schopenhauer jumped too early to a conclusion. Had he not been too eager to look over the fence which Kant had erected, he would have become not the author of a philosophical system, but the founder of a critical psychology. Had he not abused this faculty of immediate experience limited to the 'self', had he not tried to recognize the

essence of the universe, he would not have created a lopsided and almost animistic theory of universe, but a sound and critical basis for a theory of psychic functions.

If we try to look into ourselves in the same way that Schopenhauer did, without his preoccupation for finding an explanation of the universe, we may see something quite different. Following our intention of finding out of what we become aware if we depend on pure sensibility exclusively, we have to eliminate everything which belongs to intuition, that is, all factors which can be subjected to measurement in time and space, all factors which are valid in reference to objects. The true content of our pure subjective sensations can only be identified by concepts which can be applied exclusively to the subject. The only concepts at our disposal which describe exclusively subjective experiences and which can never be ascribed to objects as their properties, are the sensations of pleasure and pain—or more accurately, pleasure and 'unpleasure' *(Lust und Unlust)* of which latter, pain is only the extreme of a gamut of unpleasant sensations. Pleasure and pain are the only contents of our sensations which are objectively not measurable, which cannot appear as properties of objects, but which in spite of their objective immensurability, are not vague but very clearly conscious. As pure subjective sensations they contain the exclusive elements which constitute the experience of being subject, of being ourselves, of 'having a self', so to speak. 'I have a self', is not quite correct. It is a relapse into the habit of intellect, to treat everything including self as an object. It is more correct to say, 'I am a self' because in the pure pleasure-pain experience we are conscious only of a subject. The most accurate expression of this experience is not a grammatically complete sentence but merely the word symbol 'I' with an index connoting the pleasurable or painful quality of this purely subjective experience: [I (pleasure)] or [I (pain)].

Thus we conclude that the self as the only purely subjective experience of our own existence is determined by pleasure and pain. These are the exclusively subjective sensations.

The pleasure principle is the principle of self.[3] Pleasure and pain are either experienced or they are not; they cannot be imagined.[4] The self is the point in our system of consciousness to which we apply all our experiences. It is the ultimate token of reality. Without the self, there is no experience. The pleasure principle by which we sense that we exist, being the only principle of self, is therefore the ultimate principle of psychology. For that reason, there cannot exist anything psychological beyond the pleasure principle. The death impulse which Freud believed to be dimly recognizable beyond the pleasure principle will later be explained quite differently as not deriving from our existing as subjects. It is characteristic that Freud had to apply biological rather than psychological thinking in order to make the death impulse plausible. The self and its pleasure principle are the ultimate concept of psychology.

CHAPTER III

Up to this point we were chiefly concerned with definitions of the ego and the self. What we wish to investigate next is the relationship between ego and self.

It has been stated that the self can never become an object proper of perception. It is pure subject. It reveals itself to the conscious mind through the medium of sensations of pleasure and pain.

Of the ego, it may be said that it is not an immediate experience like that of the self, but a representation of the relationship of self to objects. In so far as it is a product of external experience, it is another external object. But it differs from all other objects in that it is intuitively perceived in the form of time, whereas the intuition of external objects takes place in the form of space. It stands between external reality and the self, having relationships with both. The rela-

[3] It is not a principle which can be applied like other principles. It is the principle of our own existence as subjects. Without pleasure or pain there can be no subject, no self.

[4] Hysterical pains are caused by imagination, but are real pains.

tionship to outside objects was covered by Kant's transcendental æsthetic. The relationships to the self are characterized by the subjective sensations of pleasure and pain which with necessity accompany the different objective experiences.

The ego, therefore, stands where Freud placed it: on the border between the subjective world of pleasure and pain, and the objective world of things.[5] These two worlds, the objective and the subjective, overlap to a certain extent. This overlapping is caused by the fact that our body which is the organ by which we become aware of pleasure and pain becomes for our perception under certain conditions, the object of our objective experiences also. The ego, therefore, is the common denominator for the correlation and corroboration of subjective and objective experiences. The functions of the ego result from the fact that the phenomenon ego occurs where subject and object come together.

The ego, being essentially knowledge, clearly cannot preexist, and must be developed as is the case with all knowledge. It is assumed that it starts to develop from birth, or even somewhat sooner. It has not rarely been observed that children are born with a thumb sore from prenatal thumb-sucking. The thumb represents in this case an object whose perception is accompanied by pleasure. This situation has all the essentials of an experience: the coincidence of an object perception and a perception of self by experiencing pleasure.

In trying to discover the essence of ego development, if one observes the behavior of the newborn and of the infant what is most striking in this behavior is that the pleasure principle seems to be fully functioning. Theoretically, in accordance with our definition of self, it could not be otherwise because the subject (self) and its manifestation (pleasure and pain)

[5] In this respect the self resembles the id. But the id also comprises according to Freud the repressed unconscious. This constitutes a confusion of functional and topical principles. If we reserve the pleasure pain function to pure subject, the self, we have a clearer theoretical basis. The repressed does not need a specific organ. As a matter of fact it functions as if it were conscious, as true motivation, eliminating only the reality test of perception.

are the necessary subjective preconditions of experience. Nevertheless, some objective sensibility must be present also because it is this sensibility which perceives objects; which is the other, the objective, precondition of experience. Observing closely the growth from birth to childhood, it is plain that the capacity to experience pleasure and pain does not develop much further; it is already fully functioning at the time of birth although at birth the sensorium of the infant is far from being at the peak of its development, either physiologically or anatomically.

The subtler senses of the infant do not seem to confer as much experience as do the more primitive senses. Sight and hearing do not convey enough meaning to the newly born child to constitute, properly speaking, real experience.[6] The infant tries to corroborate these subtler impressions with impressions of the more primitive senses which are based on contacting an object. It grabs at everything that it sees and tries, if possible, to put it into its mouth. The object which is seen must in addition be felt and, if possible, tasted and smelled before the child is satisfied. This satisfaction evidently means that the child is now cognizant of the object as an object. The disturbing strangeness of the sight of an object is dispelled by feeling, tasting, smelling, by contact. The child has literally and figuratively 'grasped' the object.

In seeing an object for the first time, the visual impressions do not confer to the infant any knowledge about the object. The visual impression is a chaotic mixture of shapes and colors without any meaning, an impression similar to that of a layman looking at an engineer's blueprint. There is a strange emptiness in an unapprehended sight. (The word 'apprehend' contains etymologically the concept of taking, seizing.) Sound is transmitted through the medium air which is much more substantial than light, the medium of vision; it stands nearer to the contact senses, and therefore better arouses a reaction of the infant's self. The more substantially the object stimulates the sense organ, the more intensive is the reaction

[6] Many animals are born blind.

of the sense organ. The contact senses proper, feeling, tasting, smelling, have greater intensity, are more capable of being evaluated by the self through the feeling of pleasure or pain. The infant reacts either with a smile or an expression of displeasure. As long as the pleasure principle is not evoked, we can be sure that the self is not aroused and that the subject is not present and therefore no experience possible.

Thus it is that the objective sense function in itself does not constitute an experience. In addition, the evocation of the subjective pleasure principle is necessary.[7] This is made possible by the intensity of the response of a sense organ. This is an important observation which permits an indirect conclusion as to the nature of pleasure and pain which would be otherwise impossible, as pleasure and pain cannot be objects of direct intuition and, therefore, cognition. Knowledge can be gained only from objects. This makes a direct objective knowledge of the character of pleasure and pain impossible. But an indirect knowledge we have of it through the intensity of sense organ reactions that evoke the pleasure principle. The pleasure principle therefore must be of a similar nature; it must be based on a principle of energy. It is the energic reaction of our bodies as a response to substantial influences from the world of objects which is the essence of feelings of pleasure and pain. And it is self-evident that our contact senses convey objects to us with much more substantiality than, for instance, our sight. This is the reason why any sight with its low intensity has to be corroborated by our contact senses in order to evoke a stimulus intense enough to arouse the reaction of self.

This corroboration of impressions by different senses means that we are able to relate them to one another. This relating of one sense impression to the impression of another sense is what is called association. After having established a firm association between two different stimuli coming from the same object, we do not need this actual corroboration any longer.

[7] The mechanisms that make contents of the conscious mind unconscious, as repression or isolation, are probably based on the possibility of disconnecting the objective and subjective factors of experience.

We become able to evoke at the sight of certain objects, the impressions of other senses without direct stimulus. For instance, once an infant has established a firm association between the sight of the breast and the pleasure which it feels when it touches, tastes and smells it, the pleasure principle will be evoked and the pleasure anticipated in the infant at the mere sight of the mother's breast.

This is similar to what Pavlov described as the 'conditioned reflex'. The only difference between Pavlov's and our evaluation of conditioned reflexes is that we do not put all the different associated sensations in one class. It is not merely a mechanical association of the objective impression of one sense with any objective impression of another sense. We can neglect the fact that Pavlov's conditioned reflexes are made up of different impressions of different objects whereas we are talking about different impressions of one single object. We are merely concerned here with associations of different sense impressions in general. If this association of sense impressions were merely mechanical, or if you prefer, objective, then we would fall back to the theories of David Hume who thought of the mind as a flow of objective perceptions unrelated to any self.[8] But by recognizing that the basic principle of the self is the pleasure-pain principle which is the constant companion of all sensual impression, we can see that the real working power in associating different sense impressions is the pleasure principle which is aroused in different sensations. In the case of the infant seeing the mother's breast it is the association of a sense impression with little power to evoke pleasure or pain with the impression of the same object on another sense which is highly capable of evoking pleasure or pain. A highly pleasant or painful impression of for instance the tactile sense is corroborated by, let us say, a visual impression of the same object which in itself does not carry enough pleasure- or pain-arousing qualities to make the individual react to it. But by associating a strong subjective pleasure or pain sensation to a predomi-

[8] This, by the way, may come close to the 'narcissistic' unrelatedness to reality which characterizes the psychotic.

nantly objective sensation the latter is able to reëvoke that pleasure or pain sensation at any subsequent occasion. The effect of such an association between different sensual impressions causes to be moblized intensive pleasure or pain sensations, in response to remote and minimal stimuli. Thus, for instance, the sight of an object formerly associated with a strong pleasure or pain sensation deriving from contact with the object can arouse the memory of the contact sensation. By ascribing the now actually nonexperienced, but remembered contact sensation to the object seen or heard, the mechanism called projection takes place if the association occurs spatially. If it is a temporal association it is called anticipation.[9]

Of the many attempts made by philosophical and psychological thinkers to build a critical psychology based on the critical method of investigation created by Kant, it must suffice here to state only that most of them accepted Kant's definition of the ego, as based on objective experience and on a representation of objective experiences, taking the subject in some way for granted. In addition, they all tried to define what most of them called by different names, as for instance, 'pure ego', or 'pure subject', what we here call 'self'. All of them failed to recognize the self as the function of the pleasure-pain principle because they applied only objective methods of logical thinking to the problem, and did not try to investigate the subjective conditions which are the concomitants of all our experiences. They all failed to recognize man's subjective interest in seeking objective knowledge. They therefore got stuck somewhere in the problem of identity which in itself cannot be analyzed logically any further. It is the limitation of 'pure thinking' that it cannot reach out much beyond the known and firmly established facts of external observation. It is understandable that the subjective pleasure-pain principle could not be recognized as the cornerstone of our very existence

[9] Anticipation is the essence of hope and fear. By its relation to time, as the determinant of our own existence in our intuition, the close relationship of fear and hope to our ego, the intuitive representation of our own existence, is surprisingly proven from quite an unexpected angle.

before its eminent importance for our psychic functions was recognized empirically. It was Freud who discovered the pleasure-pain principle as the paramount psychological principle and opened the path for us to formulate here in a critical investigation, the conditions under which experience is possible. We shall see that Freud further recognized something which we now can prove with our critical technique as being absolutely and unconditionally necessary, the recognition of sexuality as the condition which exclusively determines the functions of our minds.

All the material which is necessary to make this deduction has been mentioned. But first I wish to refer to a paper of Dr. Ives Hendrick, Instinct and the Ego During Infancy.[10] In this paper Dr. Hendrick emphasizes that in early childhood, especially in the first three years of life, sexual interests are not of such outstanding importance as the development of the sense functions in general. He tries to show that there is a certain tendency to repeat sense impressions until what he calls 'mastery of environment' is achieved. He believes that there must be a drive to learn, and that the period in which this drive to learn is developed precedes the period in which libidinal interests become of superior importance. He believes that the repetition compulsion is the result of a sense of loss of mastery over the environment caused by neurotic inhibitions. Later neurotic repetitions are merely futile attempts to reëstablish that mastery.

There is much disagreement about this use of the expression 'mastery'. I agree that it is a misnomer, but I believe that Dr. Hendrick's observations are correct. For example, a mother who frequently read the text under the pictures of a picture book to her three-year-old boy, sometimes for fun replaced by other words certain words that were familiar to the child. This evoked firm protests from the child who became distressed to the point of tears if his mother did not replace the substituted word with the familiar one. This continued until the

[10] Dr. Hendrick's paper will be published in a subsequent issue of This QUARTERLY.

child had fully memorized the whole text of the picture book. After that he started himself to repeat the joke of the mother and to make changes of his own in the words of the text. We see here a period in which a child demands repetition, followed by a period when he likes to make his own variations. What caused the child's distress was that the words with which he felt familiar were suddenly mixed with unfamiliar ones. It would be futile to analyze the meaning of the words omitted or substituted because any substitutions aroused the same distress in the boy. The real disturbance did not stem from the content of the words, but the fact that he could not recognize the words as those which he vaguely remembered. This resembles the observation with which Freud opens his book, Beyond the Pleasure Principle.

The child was still in the period of what Dr. Hendrick calls trying to achieve mastery of his environment, or, on a higher level, learning. The distress which this child showed was his reaction to the danger he felt to his weak and imperfect ego. This distress must be similar to the distress which psychotic patients show in the incipient stages of the psychotic breakdown of the ego. The whole system of not firmly established associations is threatened, and the ego is in danger of cracking. The distress of the child went deeper than any anxiety which can be traced to repressed imaginations. It is not the œdipus complex or castration fear which is the content of this child's distress. It is a danger to the unity of his ego, endangering therefore not the function but the essence of the ego.

If a position is really mastered, there is a perfect system of firmly established associations of different sense impressions coördinated with certain pleaure-pain values. This process of associating and coördinating of objective and subjective sensations continues as long as the ego is in a state of development or what might be called apprehending and learning.

We must inquire whether these mechanisms of apprehending and learning are driven by forces different from the libido mechanisms. Is there a contrasting difference between these two functions or do they flow one into the other by a mere

process of further differentiation? I believe we suffer to a certain extent in the theoretical evaluation of our observations from the fact that we interpret the child's behavior in terms which are taken from adult sexuality. Freud established his sexual theories by describing the child's behavior in terms of the conscious sexuality of the adult, both normal and pathological. In order to describe the force behind these mechanisms, the word libido was coined. But we have in several languages an expression which would serve our theories much better than the uncomfortably academic term, libido. The word is sensuality. This word expressing the deep wisdom contained in all creations of language, embraces both the function of the senses as well as sexual desire. Indeed, the child who puts a toy into his mouth trying to taste, smell, feel it, does not in essence differ from a lover, who yearns to embrace, kiss, and have sexual relationships with his beloved. Whether it be a toy or a human being with which we are in love, it is esentially the same process of apprehending by corroborating different sense impressions accompanied by the pleasure and pain reactions of the self. If pleasure is obtained we call it satisfaction. The pain of not obtaining satisfaction is called frustration. Learning can be defined as a process of obtaining satisfaction of that part of our sensuality which we call intuition (and its derivative, intelligence). If the other part of our sensuality, sensation, (and its derivative, emotion, 'feeling') seeks satisfaction, we are loving. As there is no sharp limit between intuition and sensation and therefore between intuitive-intellectual satisfaction on the one hand and sensual-emotional satisfaction on the other hand, learning and loving are practically always intertwined and form our different 'interests'. As all our sense organs show mixtures of intuitive and sensual functions, the primitive example of the child which tries 'to know' his toy is, as is all play, a simple model for any kind of psychic object relationship. What the infant does with the toy is not the symbol of a sexual act but a forerunner of it. The rôle of the child in this process of apprehending the different properties of an object in correlation to the pleasure and pain values of its sensations, can be described by saying that the child is

sensual. But there is no fundamental difference between sexual and sensual processes, and the process of loving an object is essentially a process of learning 'to know' an object. Even in this respect, the miraculous sureness of language furnishes the key word. In the Bible, sexual intercourse is referred to as 'knowing'; in German, *'Er erkannte sein Weib'*; in English, 'He knew his wife'. In German slang a figure of speech expressing a wish to have intercourse with a certain woman is, *'Ich muss es von ihr wissen'*. A patient who yearned for intercourse with a forbidden and dangerous woman, protested against advice to control himself, 'I must know how she is'. We see here that loving is the equivalent of learning, and not opposed to it. It is another form of learning, with a more complicated interplay of both actual sensual impressions and more complicated emotions based on the memories of such sensual impressions. Essentially it is the same whether we love or whether we learn. How else could sublimation be possible? How could an inhibited sexual interest find expression in a seemingly non-sexual interest if both the sexual and the sublimated interest were not of the same nature—basically sensual? I therefore cannot see that learning and loving are different things, nor that Dr. Hendrick's 'drive for mastery' is essentially different from the drive for attaining sexual gratification. Granting that the words, learning, apprehending, come nearer to describing what objectively is taking place in the infant, the whole process nevertheless is based on a general function of animal life of building up experience based on sensual perceptions; and as all sensual perception is always perceived in terms of the pleasure principle of the self, it is this invariable unit of objective sense impressions plus pleasure-pain reactions which builds up what we call experience. The ego is merely the mental representation of experiences correlated to each other on the basis of the pleasure or pain response of self. That we are essentially sensual beings establishes the rightness of the old principle that there can be nothing mental which was not first a sensation.

The deduction that the development of the ego is essentially the development of coördinated sensations evaluated according

to the pleasure-pain principle of self is the critical conclusion from the fact that our whole existence is based on sensuality; and sexuality is merely a specially highly pleasurable form of sensuality. This is the theoretical and critical deduction which confirms Freud's empirical discovery that man's nature is essentially sexual. Much of the protest and misunderstanding of those who objected to Freud's theory of sex came from the fact that the narrower term, sexuality, was used in order to denominate the wider principle of sensuality. That Freud named this ultimate principle of man's functioning 'sexuality' had different reasons. First, it was a necessary provocation, a reaction-formation against the general prejudice against all sexuality. One has to strike a harder blow than necessary in order to be a liberator; one has to be provocative. More subjectively, it is less hurtful to man's pride to imagine the child as having feelings similar to the adult, than to admit that the sexuality of the adult is nothing but a more complicated form of the child's playful learning.[11] It is not agreeable to compare a lover embracing and kissing his love to a baby putting a toy into his mouth, and it is the stubborn fight to uphold the dignity of the ego which is the actual resistance against moving the most cherished possession of one's self, the ego, from the center to the periphery of importance. However, most important in focusing Freud's interest on sexuality was the fact that this most intensive form of sensuality, once recognized in its important central position in the œdipus complex, overshadowed all less intensive, less spectacular manifestations of man's constitution as a primarily sensual being.

CHAPTER IV

Up to this point it has been tacitly assumed, not expressly stated, that man possesses motility as well as sensibility. Afferent sense impressions are conveyed by the sensory nerves in a

[11] More complicated because the objects (human beings) of later love-learning are more complex. The psychologist who tries to learn about the same objects by applying the derivatives of his distance senses rather than by contact experience is well aware of the intricacies of those objects.

centripetal direction; motility conveys the efferent motor impulses in a centrifugal direction to the organs of motion. The problem is to determine the rôle of motility in forming experience.

It will be recalled that the conclusion was reached that the pleasure-pain principle has the most important rôle in the functioning of the self because it cannot be attributed to any object, and that the subjective sensations of pleasure and pain are the only sensations added to objective sensations conveyed to us by the senses. We have to determine whether the motility has similar relations to the pleasure-pain principle of the self. Muscular movements can be accompanied by strong pleasure-pain sensations. There exists a muscle sense that may be compared to the sense of touch. If pleasure or pain accompanying muscular action is felt, this sensation is like any other sensation a centripetal process in which the moved muscle plays the rôle of an object. In cases where the afferent sensory nerve fibers are destroyed, muscular function itself does not necessarily suffer but there is a loss of coördination of movements because without sensations from the muscles they can no longer be objects of perception.

We can see no direct connection between motility and the sensation of pleasure although it is obvious that motility is in the service of the pleasure principle, but not necessary for its functioning. Motion must be considered as an auxiliary in creating experience but not as an essential factor of it. One can imagine an individual immobilized, who would still have experiences on the basis of sensation only. Plants come close to such an existence. Of course the bulk of experience of such an ideally inactive individual would be much less than of an active one, in so far as the latter can seek experiences whereas the former would have to wait for them.

Where should these energies which feed motility be placed in a psychological system? If they are not an essential part of the self, one might dispose of the question for the purposes of critical investigation, by allocating them as a part of substantial reality.

It is reasonable to consider that the substance of our bodies is a part of the substance of a space-time continuum. What distinguishes one human body substance from the rest of all external substance is merely its correlation to the pleasure principle of the individual self. This correlation is the only reason for our distinction between external objects and internal objects. The totality of internal objects represents what we call the substance of our bodies. Theoretical physics is progressively abolishing the old distinction between matter and energy as two qualities of substance, and is more and more successful in describing in terms of energy what we perceive as matter. Einstein, however, only recently stated that physicists are still far from being able to define correctly the relation of matter to energy. 'No one has been able to find out', he said, 'why matter should be in the form of discrete particles, and why each particle should carry the same quantity of electrical charge. This problem is closely connected with the direct representation of physical reality in time and space.' The human body, being substance and therefore belonging to physical reality carries energic charges also. But this energy is subject to the pleasure-pain principle which creates in each of us the experience of being a self, of being ourselves. This energy which is represented by the substance of our body is used to increase the experience of pleasure, as much as possible. It is what I would define as 'drive'. [12]

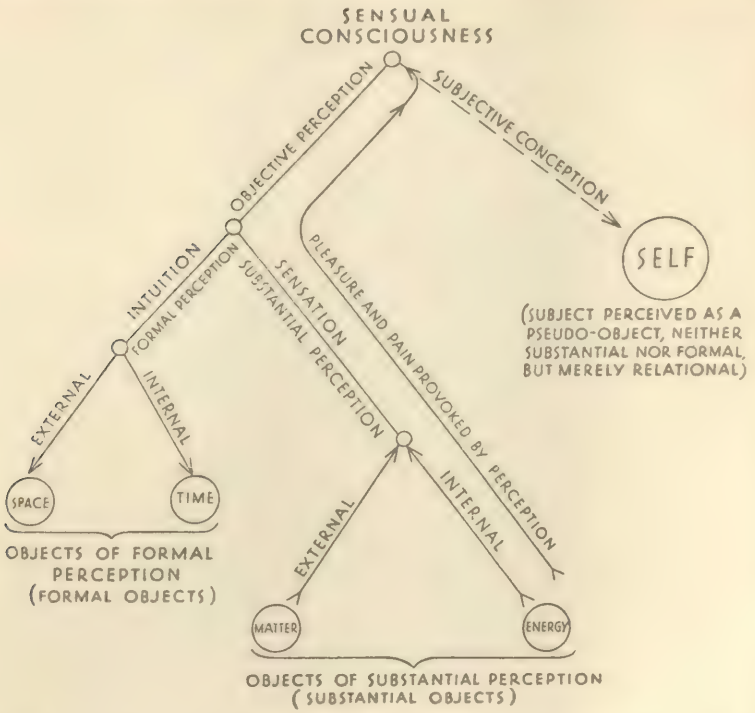
Before considering the exact position in psychology of drive energy, we should consider the differences in the perception of matter and energy in general. Direct evidence of the senses makes external solid objects appear to us as matter. Physicists would not have to try to understand matter in terms of energy if energy were directly observable in external objects. Yet, energy is directly observable, but only inside of our own bodies. Schopenhauer asserted that at the core of the personality is will. Will is a form of energy oriented towards

[12] The word 'drive' is used here exclusively to designate this energic function of our body substance. The word 'instinct' is reserved for something much more complicated which includes the substantial environment also.

apprehended reality; it is a kind of higher instinct. It is noteworthy that perception of internal objects, found only within the body substance, conveys to us essentially energic sensations, whereas external objects convey to us material sensations. What we sense as an external object is essentially, for our perception, matter; what we feel of internal objects is in essence, energy.

Although 'external' and 'internal' in this sense are largely a question of whether the object belongs to the body or not, this distinction is not the essential one; for parts of the body can be external objects because they are perceived by our external senses. We can, for instance, feel some part of the body with a hand, in which case, this body part constitutes for us a purely external object, and we perceive it essentially as consisting of matter. But we can also feel this part of the body as an internal object, if we use it actively. The tonus of the muscles, all that is felt of the body when it is being used actively, communicates to the individual a sensation of greater or of lesser intensity in terms of energy. This difference between external and internal sense perception has a very interesting parallel between Kant's external and internal intuition. Kant stated that we perceive external objects as determined by space whereas, with our internal sense, we perceive ourselves as determined by time. Thus he called time the formal condition of our inner, and space the formal condition of our outer sense. If we do not consider as Kant did, the formal conditions of perception, but the conditions of the substantial contents of our perception we can see that internally we have the substantial sensation of energy, and externally of matter. This makes matter parallel to space, and energy parallel to time. This parallelism is very interesting. It is the psychological aspect of the same problem, stated above, on which the physicists are working. Like physics, psychology can at present go no further.

I beg indulgence for yielding to the temptation to express in the accompanying diagram the relationships that have been described.



This diagram attempts to show how things and the self are consciously perceived. At the left, 'objective perception' leads to consciousness. It is divided into formal intuition and substantial sensation of objects. It has already been stated that the more substantial the sense function, the closer must it get into actual (tactile) contact with the object, to furnish the clearest substantial perception of the object possible; whereas when we use the noncontact senses (sight, hearing) we have to project [13] the impression of those sense organs on a

[13] It would lead too far to discuss the interesting problem of intuition as a projection. As such, intuition is an activity of the sense organ. Hence sense organs are not pure receptors but also effectors. In general, there does not exist any organ in a living body which is not both receptive and effective. Psychophysiologically all body organs are 'sense organs', all activities are 'projections' of inner processes (which makes behaviorism possible) whereas all inner conditions, as instincts, moods, etc., are 'introjections', i.e., receptive recordings of external influences (which makes psychoanalysis possible). Activities of the individual are recorded in the outside world by the traces

distant object, and are therefore chiefly using intuition as a means of perception. There is a minimum of intuition even in the most substantial of our contact senses, the sense of touch, and a minimum of substantial sensation in our distance senses. Therefore in all practical perception, formal intuition and substantial sensation are mixed.

The other component of perception, namely sensation which is essentially substantial, is divided, as has been explained, into external and internal sensation. Objects are conveyed to our sensorium by external sensation as conditions of matter, by internal sensation as conditions of energy. This is the whole objective perception component of sensual consciousness. The other component is much more primitive and has no subdivisions. It is not related directly to any object, although it accompanies the substantial sensations, or, more exactly, the internal component of them, the energic sensations.

Pleasure and pain are essentially a kind of relative index by which we evaluate our objective sensations. This evaluation is subjective and gives us the notion of having a self. The self cannot possibly exist as an object; it is pure subject. Whatever is not an object cannot be spoken of in terms of existence, but merely of function. Pain and pleasure cannot be qualities of an object because of their exclusive subjectivity. But we refer sensations to an inferred something which is treated as if it were an object. Thus, while sensation (pain, pleasure) is subjective, we refer it to something which we treat like an object and the source of the sensation. This reference to an object which does not exist as an object because it is pure subject, leads to the development of the ideas of a self. That self is then represented in our minds as if it were

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which an individual leaves in his surroundings during his life whereas activities of the outside world are recorded by the traces which it leaves in the body of the individual, i.e., in its nervous system, as far as psychophysiology is concerned. The pleasure-pain principle, responsible for the concept of 'self', thus being also the criterion for 'external' or 'internal', which only make sense in reference to a self, is therefore also responsible for receptivity and activity, or intake and output of energy.

an object. Self then is a pseudo object which is treated as if it were the 'source' of our subjective pain and pleasure sensations and as such an 'object' which differs from all other objects of our perception. To mark that distinction we call this pseudo object 'subject'. We feel that it 'belongs to us', that it is the inner 'source' of our feelings.

Concerning the position of the feelings of pleasure and pain, a bit of speculative hypothesis occurs to me as a possible aid in objectifying these subjective sensations, by comparing them to the phenomenon of electric induction. When an electric current is sent through a closed system of wires, an induced electric current develops in a secondary system of wires the moment the primary current is closed or interrupted. By analogy, the perception of objects represents the primary current and the subjective perception of pleasure and pain is likened to the secondarily induced current.

We have mentioned before that the experiencing of the energy at our disposal cannot be accounted for as coming from the self because the self can only be perceived in terms of pleasure and pain. The only way in which we can become aware of activity, of spontaneous energic impulses, is by way of objective and substantial perception of internal objects. Energy, therefore, is not subject but internal object. This means that we perceive energy as the property of the internal object which does not entirely coincide with our body substance, but coincides with it to a very great extent. It is important to keep in mind the complication which lies in the fact that we regard parts of our bodies as if they were external objects—as consisting of matter. But this ambiguity must not divert us from the fact that awareness of energy as something which we experience with our senses, as something which we feel, can only derive from bodily substance which is then an internal object and is directly felt as energy.

This internal object which yields the sensation of energy, makes itself felt on different levels in different ways. Biologically it may be energy which is set free by metabolism or the chemical processes of the body. On a psychological level,

this free energy is perceived as drive. It must be emphasized that drive does not belong to the self but to an object.[14] The impression we might get that drive belongs to the subject comes from the fact that the object (bodily substance) from which it really comes is an internal object. One is always inclined to regard the drives which come from our body substance as belonging to the subject, and it needs careful attention to avoid this confusion of the subject with the internal object.

Drive can be fully understood only if we apply to it what we know about energy. For it is energy, our 'own' energy. It is free energy, to be precise. Its tendency is to diminish its potential, to dissipate, and finally to reach that point where it can no longer be transformed because there is no longer a difference of potentials. It has then become entropic. This is the content of the famous second law of thermodynamics. Freud may have had this in mind in his conception of a death drive. But this character of energy is not applicable to a special drive. It is the character of all drive, not only of a death drive as opposed to a libidinal drive; for drive is merely energy felt as internal object, felt directly by our internal sense as being active in our body substance.

A drive energy of high potential is felt as tension. Freud recognized the tendency of drive to diminish its tension. This diminution is felt subjectively as pleasure.[15] This can be obtained only by discharging the free drive energy on an external object which, as described, need not be literally an external object but can also be a part of one's own body substance perceived with the external senses.

With the discharge of drive energy on an appropriate object two things, one objective and one subjective, are achieved: (1) objectively, a diminishing of the energic potential, and

[14] This fact may be responsible for Freud's conception of the id as something 'outside of the ego', something impersonal.

[15] This is true only within certain limits. The exact conditions could be discovered only by physiological investigation of the energy contents of the sense functions. Such an investigation would lead to a science of psychodynamics.

according to the second law of thermodynamics an increase of entropy; (2) subjectively an experience of pleasure sensation.

Thus Freud's theory of a death instinct has to assume that in one act of gratification, both libidinal and death impulses are gratified. In increasing entropy it is obvious that the death impulse would be gratified; whereas in the pleasure experience the libidinal drive would be satisfied. We then would have to recognize that libidinal and death impulses are not working against each other but in a parallel direction, in which case one might please himself to death. This may be said to be true in only one circumstance: if the external object is a part of the body substance, that is, if the individual for some reason cannot reach an external object and has to make use of his own body substance as an external object. This is called narcissism.

To understand this fully, the system in which the discharge of energy takes place must be clearly defined. If there is an external object on which to discharge energy the energic system works very economically. Most of the energy will be transformed and only a little part remain entropic. The more energy transformed, i.e. discharged on a foreign object, the greater is the accompanying pleasure.

But if the discharge on a foreign object is inhibited by some obstacle, objective or subjective,[16] parts of the individual's own substance will have to play the rôle of an external object. In this case his own body will simultaneously be the producer and the consumer of energy. The gradient of the energy potential cannot be great in such a system; most of the energy will not be discharged by transformation into other forms of energy and will have to be dissipated and become entropic. It is—although not very correctly—comparable to a boiler which must be cooled because the valve by means of which the steam escapes into an engine is obstructed. The pressure is thus reduced but no energic effect ensues; merely condensed steam, water, and all the fuel that was used to produce the steam is

[16] Lack of appropriate objects; fear of pain.

lost, the energy transformed into heat which is dissipated into the surrounding air.

I am inclined to say that drive is unorientated free energy. Our senses direct it to objects. The pleasure principle is the compass which indicates which object promises the greatest economy of discharge, the greatest pleasure and the least pain.

There is no death drive. Death is the result of accumulated entropic energy. In each energic process some percentage of energy remains unavailable, becomes entropic. It is a question of economy that determines when this accumulation of entropic energy reaches the critical point. The less narcissistic a psychic system, the more external substance,—the less body substance plays the rôle of external object and the more economical is the function of energy intake and output. The subjective expression of this economic ideal is the striving to obtain as much pleasure with as little pain as possible. If the objective senses give a choice between objects for drive impulses, our subjective sense of pleasure and pain is the director of our drive towards one or another. All activities, beginning with the simplest metabolic activities of the cell, up to the highest mental activities, have only one goal from the consistently subjective point of view: to obtain pleasure and to avoid pain. Oral, anal, genital, destructive and creative activities are distinguished from each other only by the different objects which promise pleasure or threaten pain. Libido is the word in psychoanalytic usage for the function of the pleasure-pain principle which attracts one towards a given object if pleasure from such a contact is anticipated. If pain is anticipated, that same subjective pleasure-pain principle produces repulsion or a shrinking away from the object. Libidinal orientation may under certain conditions be reversed from original attraction to repulsion [17] by the process of 'con-

[17] On higher levels, with richer intuitive and intellectual experiences, aversions and attractions may assume more subtle aspects, and mental object representations may be treated as real objects: we speak of wishes, desires, hopes, when object representations attract us; of disgust, revulsion, rejection, worry, if they repulse us.

ditioning'. Thus a transition from a positive to a negative (or vice versa) libidinal directioning of our drive energies is a problem which can be solved only by analyzing the past of a given individual in respect to his contact with those past experiences.

The fact that libido has a closer relationship to sexual than to other sensations comes from the fact that sexual objects (real or imagined) carry a promise of more intensive pleasure than any other objects. But the promise of all other sense objects follows the same pattern, so that our attitude to these other objects as well may be truly described as libidinal. The relationship between oral and anal sensations and sexuality comes from the fact that the first two sensations also have a high intensity, although they do not reach the height of the sexual ones and therefore cannot lead to such a sudden and complete release of energic tension as is achieved by orgasm. They are therefore very important but less economical forerunners of sexuality. The release of tension in acts of elimination has not the relieving character of orgasm, but is sufficiently similar to be a forerunner of orgasm. The psychic economy of the oral, anal and phallic phases is adequate for early childhood when the tension of the accumulated energies is not great. But for the mature individual who has a fixation in these phases, all striving for gratification of these infantile desires are uneconomical. The individual fights a losing battle against increasing entropic energy, against what is called damming up the libido.

What we wish to stress is the equality of all sensations. Sexuality is one of many sensual strivings, but a highly intensified one needing a greater psychic economy because it has greater forces to dispose of.

It is proposed to regard libido not as a drive, but as the motivation of drive to the finding of objects. The drive itself can change the object by which it is motivated, but the goal remains the same in all manifestations of the drive: to obtain pleasure and evade pain which is achieved in proportion to the amount of accumulated free energy discharged.

Freud recognized very early that his original distinction between libidinal drives and ego drives had to be given up because ego drives were found also to pursue libidinal aims. We believe that the later distinction between libidinal drives and destructive drives cannot be maintained either because libido is not an inherent characteristic of drive but is the means of motivating and directing it. To whatever action a drive may lead, whether sexual or destructive,[18] its subjective value will be appraised in terms of the sensual experience of pleasure or pain. Masochism is no exception to the rule of the pleasure principle. It is an attempt to obtain pleasure at the expense of suffering pain. As such, masochism is one of the most uneconomical psychic mechanisms. But however uneconomical, it seeks sensual gratification, sensual pleasure. This gratification is the final goal of all human activities although the objects of these strivings are as various as the objects which affect perception. One must not be deceived by the fact that the *results* of man's activities are sometimes destructive, sometimes constructive. This difference is not caused by different drives but by different subjective sensations experienced when his drive brings an individual into contact with objects. A subjective quality of pain in an experience will give a different character to an action than would pleasure. Another varying factor lies in objective circumstances. Eating is a destruction of the object, food; but this is only a circumstantial result of that specific situation and not the outcome of a destructive character of the drive. The subjective feeling might well be one of 'embracing' the object, food, with the inverted part of the body surface, the intestines. Infants can be satisfied by sucking without nourishment. There can be no avoidance of the subjective point of view in investigating psychic phenomena. That objectively ingested food is disintegrated, but that the flow of energy is then reversed by digestion, and energy is finally not lost but taken into the body—these are objective biological, physical and

[18] Destruction is one of several ways to escape from a feared object. Destruction of an object removes it from the sphere of perception.

chemical phenomena that cannot in any way be considered as subjective, and therefore, as psychological problems. To consider the objective results of our actions as their cause, and conclude that we eat to replenish our bodies, or have intercourse to replenish the race is teleological thinking and is not only unpsychological but also unscientific.

This is the first of a series of three articles by Dr. Herold on this subject. The second and third parts will appear in subsequent issues of This QUARTERLY.

THE STATUS OF THE EMOTIONS IN PALPITATION AND EXTRASYSTOLES WITH A NOTE ON 'EFFORT SYNDROME'

BY MILTON L. MILLER (CHICAGO) AND
HELEN V. MC LEAN (CHICAGO)

For centuries it has been recognized that the heart is particularly susceptible to emotional stimuli. One of the earliest cardiac diagnoses in accordance with this recognition was made by Avicenna *(1)* in the tenth century:

> 'A certain young man of Gurgan by the Caspian Sea lay sick of a malady which baffled all the local doctors. Avicenna (his identity being then unknown) was invited to give his opinion, and after examining the patient, requested the collaboration of someone who knew all the districts and towns of the province, and who repeated the names while Avicenna kept his finger on the patient's pulse. At the mention of a certain town he felt a flutter in the pulse. "Now", he said, "I need someone who knows all the houses, streets, and quarters of the town". Again a certain street was mentioned and the same phenomenon was repeated; and a third time, when the names of the inhabitants of a certain household were enumerated. Then Avicenna said, "It is finished. This lad is in love with such and such a girl who lives at such and such an address; and the girl's face is the patient's cure." They were brought together and married and the cure was completed.'

In this case the patient had repressed the entire conflict, even his awareness of love for the girl. The physician perceived a part of his patient's conflict (love) but not the fear which it engendered.

Extrasystoles produced as a result of emotional stimuli are mentioned by Wittkower as having been first observed by Nasse *(13)* in 1918. During the past two decades the develop-

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ment of diagnostic methods has made for much greater precision in differentiating organic from functional heart disease, and has led to a recognition that at least fifty per cent of the patients who consult a physician because of heart symptoms have no demonstrable organic lesion of the cardiovascular system, and that even where actual cardiopathology can be proved there are in thirty to thirty-five per cent of these, symptoms which can not be explained on an organic basis but which are functional in character.

Among the numerous cardiologists who have studied cardiac neuroses alone or in conjunction with organic heart disease, outstanding contributions have been made by Ryle *(14)*, MacWilliam *(12)*, and MacKenzie *(11)* in England; Connor *(4)*, White *(17)* and his coworkers, Kilgore *(8)*, Christian *(3)*, Boas *(2)*, and Weiss *(15)* in this country. In such contributions the physiopathological aspects of the problem are dealt with exhaustively. The psychopathological descriptions however are in general terms such as, 'emotional disturbance', 'worry', 'grief'.

In Emotions and Bodily Changes, Dunbar *(5)* has summarized the psychological findings in the literature pertaining to cardiac neuroses up to 1938. From all the attempts to delineate the emotional situation which may be in causal relation to the cardiac symptoms, up to that date, of chief interest are the findings of MacWilliam *(12)*, Wolfe *(19)*, Karl Menninger *(9)*, and William Menninger *(10)*.

MacWilliam *(12)* in studying the effect of dreams on circulation, noted marked palpitation, increased heart action, increased pulse rate, and greatly raised blood pressure in an individual who awoke after a dream 'in which he felt lively resentment at the irritating conduct of an official on a public occasion'. From his studies MacWilliam *(12)* concluded that such an emotional disturbance in sleep may cause hemorrhage, anginal attacks, or even ventricular fibrillation.

Lewis Gunther and Karl Menninger *(7)* made electrocardiographic records of a female patient who had intermittent attacks of extrasystoles when she was being prepared for a

pelvic examination and while the examination was being made. Her history showed that she had considerable conflict over sexuality. While the case was not explored in great dynamic detail, the authors suggest that the anxiety connected with sexual stimulation contained an element of hostility, and that both fear and hate were 'expressed autoplastically'. Psychoanalytic observations upon cardiac disorders are reported by Karl and William Menninger *(9)*, and in a later paper by William Menninger *(10)*. They stress the importance of unconscious factors which may be associated with the production of cardiac symptoms. In a summary of their observations the authors state that 'the heart disease and heart symptoms are sometimes reflections of strongly aggressive tendencies which have been totally repressed, and appear characteristically in a man who is strongly attached to the father and hostile to the mother'. The hostility to the father is repressed and if the father has heart disease or heart symptoms the patient 'includes these symptoms in his identification with the father, to carry out the inexpressible patricidal impulses reflexively by unconscious focal suicide'.

William Menninger *(10)*, in a later paper, points out the connection between cardiac symptoms and repressed unconscious hostilities.

In a paper entitled Effort Syndrome, published by Wittkower, Rodger and Wilson [1] *(18)*, in Lancet in April, 1941, the findings in fifty cases of soldiers between the ages of twenty and fifty, all suffering from effort syndrome, are described and classified. This study is in harmony with our own psychoanalytic findings and corroborates impressions we received regarding the unconscious conflicts of our own four psychoanalyzed patients suffering from similar functional cardiac symptoms.

In the soldiers studied by Wittkower and his associates *(18)*,

[1] This valuable paper appeared some months after our present study was given at a meeting of the Chicago Psychoanalytic Society, April 12, 1940, and at the Joint Session of the Psychoanalytic Section of the American Psychiatric Association with the American Psychoanalytic Association, May 22, 1940.

cardiac symptoms were among the most prominent and consisted of cardiac pain, palpitation, 'fluttering in the chest, as if the heart was going to stop or burst—usually connected with fear of impending death'. They found that the soldiers fell into five personality groups: those in Group I (twenty) were characterized mainly by 'a keen sense of duty and by a rigid superficial and deep morality, and with severe repression of their aggressiveness'; Group II (eleven) showed a similar structure but were less inhibited in their aggressiveness, and particularly tended to be defensive of the 'underdog'; Group III (only three) apparently overcompensated with overaggressiveness, but then took flight into illness; Group IV (twelve) were constitutionally of inferior physique, too much attached to their mothers; Group V were quitters who seemed to have inadequate egos and to have given up the battle in their early years. Although these five groups present superficial contrasts, fundamentally they all appear to present the same basic structure—conflicts about the same issues which were a source of difficulty in our own four patients. All of these fifty soldiers had chronic personality difficulties which seemed to bear directly upon their cardiac illnesses.

Before we give the specific emotional setting in which palpitation, precordial pain, and extrasystoles occurred in our own patients, we wish to digress in order to mention a dream of Freud *(6)*, which he quotes in the Interpretation of Dreams, and from which he awoke with palpitation.

> 'I tell my wife I have some news for her, something very special. She becomes frightened, and does not wish to hear it. I assure her that on the contrary it is something which will please her greatly, and I begin to tell her that our son's officers' corps has sent a sum of money (5,000 k?) . . . something about honorable mention . . . distribution . . . at the same time I have gone with her into a small room, like a store room, in order to fetch something from it. Suddenly I see my son appear; he is not in uniform but rather in a tight-fitting sports suit (like a seal?) with a small cap. He climbs on to a basket which stands to one side

near a chest, in order to put something on this chest. I address him; no answer. It seems to me that his face or forehead is bandaged, he arranges something in his mouth, pushing something into it. Also his hair shows a glint of grey. I reflect: Can he be so exhausted? And has he false teeth? Before I can address him again *I awake without anxiety, but with palpitations.* My clock points to 2:30 A.M.'

In his associations, Freud *(6)* recognizes his own competitive attitude towards his son and the envy of his son's youth.

First Case

A conscientious young business man of austere upbringing came to analysis because of hypochondriacal fears, especially related to his heart. He was afraid that he might die of heart disease. For six months he had felt a dull ache over his heart and occasionally mild pains in his left arm as well as palpitation and extrasystoles. A physical examination prior to the beginning of his analysis was negative. A recent electrocardiogram showed some slurring of the R-S complex and a left axis deviation. There was a slight sinus arrythmia but no extrasystoles. The cardiologist interpreted the electrocardiographic findings as a result of childhood diphtheria and scarlet fever.

In the initial interviews the patient, who is very intelligent, seemed unduly meek and subservient. This paralleled his attitude of passive submission to his father. Later, when he mentioned his father, he gave an important clue to the unconscious origin of his difficulties by a casual remark. His father had died three years before of a second attack of coronary occlusion preceded by a period of angina pectoris. The patient mentioned the first coronary occlusion, and added in an offhand manner, 'That didn't finish him, he lived for six months after that'.

The patient's cardiac symptoms which had been especially prominent for six months, coincided with the beginning of his work in a minor capacity in the business concern which his father had been instrumental in founding and which

bore his father's name. The symptoms coincided also with the time of year of his father's coronary attack.

In his life to date, the patient had been passive, compliant, and had always preferred the easy way. He had been unable to decide on a career, and at college had been most interested in precisely those subjects about which his father knew little. When he finished college he wanted his father to arrange a sinecure in the business for him, but he was refused. He was employed in a bank for several years where he did poor work, and felt bitter about the fact that his father's partners were getting good jobs in the business for their own sons. After his father's death, the patient went to work in the family business but harbored resentment towards the president, formerly his father's partner, because he offered the patient only a minor position.

The patient's unconscious competitive attitude towards his father is dramatically illustrated in a dream which recurred several times at the beginning of the analysis.

> His father is not quite dead, but, over a long period of time, is suffering, writhing and groaning.

His associations refer to his fear and resentment of his father, his feeling that the father never helped him enough, and his worry over his own cardiac symptoms, namely, palpitation, extrasystoles, and numbness of the left arm.

During an interruption in the analysis, the patient had two dreams which he reported when the analysis was resumed. The first was accompanied by several weeks of extrasystoles, the second by intense palpitation and fear of imminent death.

> *First Dream:* I thought father had heard about my having an automobile accident, running into another fellow's car, after I had had a few drinks. I tried to keep it a secret. Father tried to get me to meet him face to face and have it out. I didn't want to.

His associations referred to his learning that he was to be a candidate for the presidency of a tennis club of which he

was a member. This news preceded the dream. He reacted with intense fear, violent palpitation and extrasystoles, at the thought that he might be elected and have to make a speech at the banquet. He unconsciously equated the possibility of his election with a victory over his father, hence the intense fear and the guilt in the dream. This dream also represented his wish to resume analysis.

The second dream, which occurred a few weeks later, gives us further insight into his unconscious attitude towards his father.

> *Second Dream:* On the ceiling of the family's summer cottage there were two spiders together in some kind of movement. The male was a hairy tarantula, the female was beautiful like a dove.

The patient awoke with violent palpitation and fear, and thought of his father's death. He associated his father as the tarantula and his mother as the female spider. He had often felt his father was dirty, crude, etc., and had always felt the same attitude towards sexual intercourse. He had a lifelong fear of spiders. Further associations referred to the first dream of the automobile accident. This second dream reveals one of the important sources of the patient's unconscious hostility towards his father, namely, envy of the father's sexual relation to the mother which he actually witnessed repeatedly since he slept in the parents' bedroom until he was seven or eight years old.

In a later hour he was fearful, tense, felt his face alternately flush and grow pale, and experienced some extrasystoles. These symptoms occurred during a session in which he related a dream in which he won in a competition with another man, had intercourse with a girl and then felt guilty. He recalled his fear of his father and his confusion at six years of age when he learned that his mother was going to have another child and vaguely realized the rôle his father played.

For a few weeks following the resumption of the analysis, the patient continued to experience frequent extrasystoles

daily. An interesting example was the patient's response to an interpretation with an extrasystole. During this hour he was expressing his anger at his wife's recent pregnancy and his unwillingness to take on the added responsibility, by depreciating and criticizing her. When the interpretation was made that he avoided analysis of his attitude towards his wife, since it is connected in his mind with his previous attitudes towards his mother, he immediately responded with an extrasystole and remembered his fear of his father as well as his envious hostile attitude towards his superiors.

Second Case

A college student came to analysis because of marked tenseness, inability to choose a career, and a history of previous nervous breakdowns. His father was a strict, stern, intensely competitive, Napoleonic type of business man with whom the patient felt unable to compete. However he tried to outdo him in scholarly achievement and in his daily life was exceedingly submissive to his father. He tried to repress his passive homosexual attitude, but it found expression towards other men in his efforts to exhibit himself intellectually. This patient's hostility was nearer to the surface than that of the first patient described. He got into trouble frequently but always took flight into ill health.

During the analysis he often experienced palpitation and sometimes extrasystoles connected with his feelings towards his father, especially when he was becoming conscious of death wishes towards him. On one such occasion he perspired, felt anxious, noticed some tachycardia, marked dyspnœa, and pounding of the heart.

Such an emotional situation is clearly illustrated by a dream during this period.

> My father was lying down in great distress physically. He had a heart attack, and his pulse was very rapid.

The patient associated his father's attacks of gastrointestinal distress, and recalled his father's fear of death. Then he

recalled that he was told by the family physician that he was a replica of his father. He wished his father would die, then remembered that he himself had always had fears about his heart. He added, 'Maybe I was afraid he would die and maybe I felt he would bring some kind of attack on me because I wished it on him'.

Third Case

A forty-year-old chemist sought treatment because of generalized dissatisfaction with his personal life, frequent periodic drinking, and repeated attacks of extrasystoles. He had been brought up in a pious atmosphere. All of his conscious anxiety was related to his fear of the consequences of his drinking bouts and to the extrasystoles. At certain periods, showers of extrasystoles would recur during one to several days. Then for no apparent reason they would disappear. His heart had been examined several times by cardiologists and had been found organically sound. In spite of reassurance, he continued to be obsessed by the fear that he would die of heart disease as his father had.

The patient was the fourth of six children. Neither the patient nor any of his siblings had ever married. Consciously he depreciated marriage and emphasized the disadvantages of being tied down to one woman and a responsible relationship. Unconsciously he revealed intensely rivalrous hostility against any man with a wife and a well established home. In his profession he had as his immediate superior a man really inferior to the patient in intellectual capacity. Whenever his competitive urges began to interfere with his passive relation to this superior, he would begin drinking. The self-destructive nature of the drinking was clearly shown by the fact that he would drink himself into unconsciousness in his laboratory where he could have been discovered and discharged. Occasionally his work and his own narcissism required that he equal or excel his superior in a way calculated to arouse the anger of this man. During such periods the extrasystoles occurred, subsiding when the patient could once more slip back

into a passive submissive relation to his superior. Whenever the patient was struggling against a sexual interest in the analyst's wife and against a wish to marry a woman who represented his mother he would have showers of extrasystoles during the time such matters were under discussion. Unconsciously the patient felt positively identified with his father. His hostility towards any father figure arose whenever he felt propelled to engage in a rivalrous struggle with a loved father. He attempted to hide his sexual interest in a mother figure by a conscious depreciation or scornful attitude towards her. When this failed and when he was becoming conscious of his jealous rage against a father substitute, he expressed autoplastically symptoms similar to those which had caused the father's death.

Fourth Case

A conscientious, ambitious woman, who had been brought up in a strictly moralistic household, had been under treatment for some years when she reported that three weeks previously she had for the first time in her life begun to suffer pain around her heart associated with single or multiple additional heart beats. She was frightened that she might have some form of organic heart disease, although she told herself that the cardiac symptoms were undoubtedly caused by some emotional tension. She consulted an internist who after a thorough physical and electrocardiograph examination reassured her that her heart was organically sound. The precordial pain and extrasystoles continued however for several days following the internist's reassurance. After the patient awoke from a dream, the meaning of which was in part clear to her, the cardiac symptoms disappeared and had not recurred up to the time of consultation with the woman psychiatrist. Two days later the patient wrote to the psychiatrist giving further associations to the dream. While writing this letter the precordial pain momentarily recurred. The essential history of the patient is as follows. She is a forty-eight-year-old unmarried woman who had been successful in the nursing profession.

She had been a rather withdrawn, slightly eccentric individual, but viewed superficially, her professional and social adjustment seemed adequate. During 1931–32 she had her first sexual affair. Her lover was a man six years younger than the patient. In many physical and mental characteristics he resembled the patient's father. His given name was even the same as her father's name. The patient had developed increasing anxiety which made her withdraw from all professional and social contacts, but during the past eight years a gradual process of rehabilitation had taken place. Later, the patient was offered an excellent position. She became immediately anxious, predicting that she would only fail. While she was attempting to reach a decision about the job, her psychiatrist went away for ten days. It was then that the cardiac symptoms appeared.

During the recent consultation, she said: 'I've always been afraid of heart disease because I remember as a small child hearing a doctor say, "That one will die of heart disease". Then I always thought mother died of heart disease. [The patient's mother died when she was eight years of age.] That's why I was so worried over the pain and extrasystoles. In the dream you were a French woman, not very tidy and a little too fat. You were singing songs in some place like the Institute where there were a lot of men around you. You were singing, *"Je ne sais pas ce que je suis"*. You were French, immoral, and loose. From what you were singing you must also have been me, or my mother.' The patient gave further associations in a letter written two days later: 'I must write to add what I know I did not include in the dream. The woman was diseased, venereal or leprosy—also infectious, and the skin was white like your skin, like camelias. I tell myself this and try to convince myself it is not like funeral or wedding flowers. They are a carnage. I think of my mother after she died. Perhaps when much affected one feels she is placing a spell by thinking a thing and in wishing a mother dead; one killed her. Once was enough without doing so to you. After all, the woman in the dream was a prostitute.

In writing this sentence I had a pain in my heart for the first time in several days. I wish all social workers, teachers, and especially nurses, exploded and blown away.'

The meaning of the dream is clear. In reëstablishing herself in her profession, the patient felt that she was competing not in a professional sense alone but also in a sexual way with her psychiatrist. If the psychiatrist were dead of heart disease like her mother, she could then be in her place surrounded by men. At the very moment when her hostile competitive attitude was becoming conscious, fear of retaliation and fear of loss of her psychiatrist's love overwhelmed her. As a punishment for her hostility, she identified herself with her mother who died of heart disease. A temporary relief from her cardiac symptoms came as a result of spontaneous insight into the sexually competitive meaning of the dream. With the complete confession not alone of her sexual rivalry with the psychiatrist but also of her death wish, intense fear of retaliation again caused momentary cardiac disturbance.

Discussion

It is clear that the appearance of palpitation and extrasystoles in the patients we have described is connected with anxiety. What are the specific emotional situations with which this anxiety is connected?

An outstanding feature in our cases is the fact that the symptoms always appeared at a time in the analytic situation when the defenses had been worked through and the strong competitive attitude towards the parent of the same sex appeared. In each case our patients gave the impression that the parent of the same sex represented an overwhelming, fearful adversary with whom they had always unconsciously been engaged in a desperate struggle—a struggle which they wished to avoid at all costs because this parent was also unconsciously a loved person; in life they expressed this love in the form of a strongly submissive attitude. To submit rather than to fight was the keynote of their lives.

As the analysis proceeded to the exposure of the conflict

with the parent of the same sex, the patients were impelled towards a more active and aggressive attitude. This did not necessarily express itself directly in sexual competition, but the patients felt that they must prepare to engage in competition with a powerful rival. The active attitude, as the analysis brought it nearer to consciousness, was blocked for the following reasons: (1) the competitive aggressive attitude aroused too much guilt, and the punishment for such hostility was often expressed by means of identification with the cardiac symptoms of the parent; (2) the competitive urge threatened dependence upon the loved parent and aroused fear of losing the parent's love. This strong attachment inhibited the patient's flight.

Identification with a parent of the same sex who had cardiac symptoms has been mentioned as a feature of three of our four cases, and in two cases which Dr. Thomas French mentioned to us in a verbal communication. The ambivalence in our patients expressed in the identification with the heart symptoms of a parent is characterized by the dominance of the unconscious love for the rival parent, and dependence upon him, as opposed to concomitant hostility. Although functional cardiac symptoms also occur when neither of the parents have had heart disease, cardiologists have long noted the frequency of their incidence in relatives or close associates of patients with cardiac neuroses. However, although our patients identify with the parent's heart disease in connection with a specific emotional situation, they do not have the same symptoms as the parent. For instance, the business man (first case) whose father had died of a coronary attack and who previously had suffered with angina pectoris had palpitation and extrasystoles. The onset of such cardiac symptoms mobilizes hypochondriacal fear which then contributes further to the anxiety and is used by the patient as a rationalization for the anxiety.

Upon going over the case records summarized in the paper of Wittkower, Rodger and Wilson *(18)* we observed in the majority of them the following similarity to our own patients:

when an increased competitive drive was demanded of these individuals, they were unable to direct aggressive energy toward the competitive goal, and instead of being vented in actual muscular activity the stimulated energy apparently was transformed into cardiac symptoms. Especially in Group I, there was a 'fear of showing fear', and it would seem that the superego conflict apparently blocked the impulse towards flight as well as the impulse to fight.

Wittkower and his associates *(18)* emphasize the strong sense of morality, religion, conscience and duty found in so many of their effort syndrome patients, and contrast the stern, religiously moral type with the colitis type whose conscience demands overcleanliness, and the peptic ulcer patients who are conscientious about earning their 'bread and butter'.[2]

Palpitation is a biological manifestation of fear in the face of danger. The increased pulse rate and intensified heart action make the individual subjectively aware of the increased activity of the heart. Situations which produce palpitation involve an immediate urge to activity and at the same time fear of it. Common examples are: palpitation experienced upon receiving a rebuke from one's superior, taking an examination, going to a forbidden amatory rendezvous and the like. In all of these situations the individual is driven by his active, ambitious attitude into an apparent danger which at the same time he feels an urge to avoid. His flight is blocked.

Our patients react to competitive situations similarly. The competitive activity, if it had been carried out, would normally have been discharged in muscular movement; instead, it appeared in the form of cardiac responses. Their analyses

[2] Connected with the effort syndrome, they found breathlessness and depression very frequently present. Respiratory illness was frequently associated with onset of cardiac symptoms. We believe it is possible that the breathlessness and respiratory symptoms are associated with fear of separation from an object upon whom the patient is dependent, and the depression may be connected with guilt over hostility to the loved person. See French, Thomas M., and Alexander, Franz et al.: *Psychogenic Factors in Bronchial Asthma.* Psychosomatic Med. Monograph, IV, 1941.

pointed clearly to the origin of the conflict in the œdipal situation. While all of our cases experienced extrasystoles as well as palpitation, it is not clear just why extrasystoles occur in the specific emotional situation described; perhaps further physiological studies may throw light on this question.

In the psychoanalytic treatment the dangerous situation had to be faced, and when the relation between the symptoms and the emotional situation became clarified, the symptoms improved.

It is interesting to compare our cases of palpitation and extrasystoles with hypertensive cases studied psychoanalytically at the Chicago Institute for Psychoanalysis. The hypertension cases appear to be fixated at a constant, strongly rebellious attitude towards the rival parent. As. Dr. French has stated, they appear to be fixated on an obstacle which prevents them from approaching their goal, but from which they cannot retreat. In the hypertensive cases, the emphasis is on rebellion as a protest against a strong unconscious passive submissive attitude. By contrast our patients suffered from palpitation when they were much nearer to tackling the competitive situation but were inhibited at the point of expressing competitive hostility.

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PHYSIOLOGY OF BEHAVIOR AND CHOICE OF NEUROSIS

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It is an old and often repeated observation with which all analysts are familiar that a dream will frequently anticipate the onset of a somatic symptom or even of an organic illness. As an example I may cite from one of our asthma patients a dream which Dr. Helen McLean has placed at my disposal.

The patient, a forty-six-year-old, rather inarticulate laborer, had just started an analysis for bronchial asthma. The following dream was reported in the twelfth hour of his analysis and was probably a reaction to the analyst's first interpretation of a dream in the tenth hour.

> 'I can't remember it. It was about father and mother. It seems mother was doing blacksmith work. She had hot iron and was hammering.'

When the analyst reminds him that his father was a blacksmith, he adds a few details.

> 'Father was also in the dream but not so clear as mother. He was standing at the side of the shop—kind of dark. I plainly see my mother. She had hot iron and working at it, flattening it out and bending it, doing clean work, good job too.'

In association he protests that his mother never did any blacksmith work although she sometimes came to the door of the shop.

Corresponding to the patient's inarticulate character, he is quickly through with his associations, so the analyst tries to help him out. She suggests that perhaps she seems like a woman doing a man's job.

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It seems quite certain that the analyst is right. Probably the patient was somewhat disappointed at being assigned to a woman analyst but he has evidently been quite fascinated by the analyst's interpretation of his dream a few days before and is beginning to feel that she can do as good a job as if she were a man. He does not reply to the analyst's comment but continues to dwell admiringly upon the details of the mother's work in his memory of the dream:

> 'Father was standing on one side. Mother took the iron out of the fire, performing the work on it—a long piece of heavy iron.'

The iron resembled an iron used on locomotives to pull out clinkers. The mother was shaping it. There was a hook on the end of it.

If the mother's beating an iron bar on the anvil represents the patient's treatment, it would seem that the patient must be thinking of himself as the bar that is being beaten and bent. The analyst comes to this conclusion and remarks that if she is bending the patient like iron, he must be afraid. He partially confirms this interpretation. He agrees that he really is afraid of the analysis. He does not know what it is all about and feels helpless because he is in the dark.

My particular interest in presenting this material consists in its relation to the sequel. This dream, as we have seen, pictures vigorous muscular activity on the part of the mother and seems to represent the patient himself as being beaten upon an anvil. It seems like a sort of continuation of the dream, therefore, when we learn in the next hour that two days later he developed lumbago, and in the fourteenth hour, a week later, he complained of a stiff neck so painful that he could talk of little else during the entire analytic hour.

There are three possible ways to explain the onset of these muscular and arthritic pains which occurred within a few days after this dream of violent muscular activity.

(1) It may have been merely a coincidence. The difficulty with this view is that 'coincidences' of this sort occur so frequently.

(2) Freud (1925) has pointed out that an inflammatory or other pathological organic process may be unconsciously perceived some time before the symptoms to which it gives rise are sufficiently acute to attract conscious attention. This suggestion is supported by a number of observations in which dreams have seemed to predict organic lesions that developed later but which at the time even careful medical examination was unable to discover.

(3) As a third possibility we may perhaps surmise that the violent activity in the dream may be reflecting some intense excitation in the muscles or in the associated nervous pathways corresponding to the wish to beat or be beaten of which the dream is an expression. The subsequent muscular and arthritic pains would in this case be at least in part the result of this intense functional excitation.

In confirmation of this third possibility may be cited numerous dreams reported in the literature in which the dreamer awakened to find that he was acting out the impulse of which he had just been dreaming. Thus one might dream of a little boy masturbating and wake up to find that the dreamer was performing the act which his dream had attributed to the little boy; or he might dream that he was striking someone and wake up to find that he was beating the pillow. Some years ago Dr. Leon Saul (1935) collected a number of instances to show that symptoms that seemed to be psychogenic in nature are often the result of activities during sleep of which the dreamer only later becomes conscious. Instances like these are sufficiently numerous it seems, to warrant the assumption that activity represented in a dream is likely to indicate some sort of functional excitation or even activity of the organs that are involved in the dream activity and that subsequent symptoms involving these same organs will most probably be also the result of these functional excitations or tensions.

We seem justified, therefore, in the conclusion that the manifest content of a dream may be a very valuable indicator of physiological excitations and tensions corresponding to the wishes and impulses of which the dream is an expression. Indeed if we study the dream more carefully I believe that we

can go further than this. By careful study I believe it is often possible also to gain some indications of the shifts in the patterns of physiological tensions that have taken place during the dream work. Let us take again as an example the dream of the mother beating the iron bar.

We have not yet raised the question as to why Dr. McLean's patient should have come to his treatment with the expectation that it is the analyst's job to hammer him into shape just as his father used to bend iron bars upon the anvil. This seems indeed to be an exceedingly masochistic concept of the analysis and would seem to imply that the patient was suffering from a very great sense of guilt and need for punishment. We have not time in this short paper to give a very complete reconstruction of the latent content of this dream, but it will be of interest at least to make an attempt to trace the source of this sense of guilt.

We have not reported the content of the dream interpretation in the tenth hour for which this anvil dream of the twelfth hour expresses so much admiration. This patient's analysis had opened with a very considerable reluctance and embarrassment on the patient's part to bring into the discussion his discontent with his marital life and his great resentment of his wife whom he criticized as fat and exceedingly sloppy in her dress and in her housekeeping, and very neglectful of their two children.

The dreams reported by the patient in the tenth hour dealt with this embarrassment at complaining about his wife to another woman. In one dream fragment which was particularly embarrassing to him he was trying to avoid his wife in a railroad station and another lady was sympathizing with him and asking why he had married her. The analyst interpreted this dream as the fulfilment of a wish that she sympathize with him in his desire to separate from his wife. In the discussion which followed, the analyst had occasion to point out that the patient had really married his wife in the expectation that she would take care of him like a mother. Now in the analysis the patient was unconsciously hoping that the analyst would play

the mother rôle which the patient so missed in his wife's attitude towards him.

The patient must unconsciously have sensed in this interpretation an implication of sexual interest in the analyst inasmuch as the next day he stated that he never put any value in dreams and spent most of the hour protesting that he could not stand the idea of 'wives and mothers' talking about sex. However his dream in the twelfth hour reveals that this was only one-half of his reaction to the analyst's interpretation. Deeper down, he was much impressed.

It is now easier to understand why the patient felt the need to be beaten by the analyst.[1] Unconsciously he is intensely chagrined on account of the sexual interest which the analyst unconsciously awakens in him. The iron bar that is being beaten and bent is probably a symbol of his erect penis. Actually in his young manhood his choleric father had twice beaten him for his sexual activities, and in a dream much later in the analysis the patient himself is beating an iron bar which has the shape of a penis.

Let us now sum up the physiological implications of our reconstruction of the dream work. The dream seems to imply that the dream work started with sexual excitation, very probably an erection, associated with sexual wishes stirred up in the analytic situation. He reacts to this sexual excitation with intense guilt and develops an impulse to beat himself or be

[1] Analysts will recognize in this dream a still deeper source of the patient's need for punishment. Later in the analysis he recalled that his resentment of his wife had begun during his wife's first pregnancy and had become more intense during a second pregnancy and that its deepest root lay in jealous resentment of the wife's relation to the two children. One of the central themes of the analysis was in fact the patient's intense resentment of his mother's pregnancies (he was the eldest of six children) and his unconscious impulse to take the unborn child from the mother's body. It will be noticed that this wish is symbolized in the iron bar with a hook at the end to remove clinkers from a furnace. Physiologically interpreted this dream suggests that the mother is beating down his erect penis into a grasping hand—an interpretation which corresponds with his mother's actual attitude towards him, her sharp inhibition of his developing genital sexuality and her urge to keep him a child, at least in the sexual sphere.

beaten. This we suspect finds expression in some sort of tension or even activity in the muscles and in the associated nervous pathways. If we observe carefully, however, we note that this is not the final step in the dream work for the manifest content of the dream does not represent the patient as beating or being beaten but rather as watching his mother beat an iron bar. If we follow literally the physiological implications of this fact we must suspect that this projection involves a further displacement of excitation away from genital excitement, and from the impulse to muscular activity, to the visual apparatus. We might compare the significance of such a displacement to that of a man who inhibited his impulse to beat up someone and attempted to relieve the tension by going to see a movie that was characterized by a good deal of violence.

You will perhaps ask me how literally I am inclined to accept this physiological reconstruction. Do I believe that the dream work was actually accompanied by physiological excitations and tensions such as I have described? If you ask my impression, I shall say that on the basis of the analysis of the interrelations between a great many dreams, I would be inclined to believe that the physiological reconstruction we have made would correspond roughly to the actual course of distribution and displacement of functional excitation during the dream work, but I must admit that without examination of a great deal more material than I can present in a short paper, I would be unable to prove it. Nevertheless I believe that there is a great deal of value in attempting to reconstruct the apparent physiological implications of our interpretations of dreams and other psychoanalytic material. The method as I have indicated by this example is to trace step by step the pathway from the wishes that motivate the dream to their expression in the manifest content of the dream and to pay careful attention to the organs or organ systems whose activity is implied in each of the steps of this process. We cannot perhaps be sure that what comes out will correspond in all details to the actual patterns of physiological excitation that accompanied the dream work but I believe we have sufficient reason to suspect that it will

have a fairly close relation to these physiological patterns and that it can form a good basis for further investigation (by comparison with other dream material of the same patient and by physiological experimentation, etc.) to test the rough hypotheses derived in this way.

Analysts will notice that what I am here proposing is merely an attempt to develop in very explicit form a procedure which analysts have long used in terms of Freud's original libido theory. We have long been accustomed to attempt to explain numerous psychological mechanisms by displacement of libido from one organ of the body to another. My only innovation in this procedure is to discard as unimportant the old and meaningless controversy as to whether the energy that is shoved about in these displacement processes is of a sexual nature or not. I think it is much more important to recognize that these displacements of energy are really of functional significance. As a matter of fact every integrated activity involves the functional excitation now of one organ, now of another, according to the particular pattern of the activity. One moment we are looking, another we are thinking, and then there may be motor discharge. I believe it is introducing entirely unnecessary confusion to conceive of these 'displacements of energy', when we encounter them in the dream work, as some sort of mysterious displacements of libido.

One of the most reliable ways of testing such hypotheses as these concerning the physiological excitations accompanying the dream work is by noting how far somatic symptoms that develop in the course of a psychoanalytic treatment correspond to what we might have expected from our physiological reconstructions. We have already discussed one example of such a correlation in noting that the forcible activity pictured in this anvil dream was followed within a few days by severe pains in all the muscles of the patient's body.

In fact, observations of this kind seem to suggest a very simple rule by which we may guess in many instances what organ will be chosen in a particular instance for the somatic discharge of an emotional tension. We are all familiar with

Stockard's experiments (1921) in which he demonstrated that developing organisms exposed to some more or less indiscriminate toxic agent would be most damaged at precisely those points that were developing most actively at the moment of exposure to the poison. A similar principle [2] would seem also to hold in our problem: symptoms resulting from the frustration of an activity are likely to involve especially the organs which are most active or most under tension at the moment of frustration. This principle is well illustrated in our reconstruction of the 'anvil dream'. Our hypothesis in this case was that the dreamer was activated by a strong impulse to violent muscular activity but that the manifest content of the dream seems to represent an attempt of the dreamer to withdraw energy from these impulses to muscular activity and to content himself with a visual picture of the activities to which he is impelled. The attempted displacement to the visual apparatus already indicates an energetic effort to inhibit muscular discharge. In accordance with the principle just formulated we should expect that symptoms developing at this time would involve the organs whose activity is being with difficulty inhibited—in this case the muscles and joints—and this proves in fact to be the case.

By contrast it will be of interest to describe a rather similar physiological pattern that seems to be followed regularly not by muscle and joint pains but by severe frontal headache. The physiological pattern, in these cases also, involved the displacement of excitation away from energetic muscular impulse to visual and intellectual activity; but in the cases to be cited the inhibition of muscular discharge is much more complete. In the dream that we have just cited the patient seemed to be trying to satisfy his own need for violent activity by observing the violent activity of someone else. In the instances about to be reported the inhibition of motility has gone much further. Instead of observing an active figure, the patient is

[2] I believe that this principle which is already implicit in Freud's early papers, has been somewhere explicitly formulated, but I have been unable to find the reference.

fascinated by a motionless figure. The need for activity is not only projected; it is also denied. In accordance with our principle to expect the somatic symptom in the organ that is most under tension, we find that in these cases the patients develop a headache.

I am sorry that time permits me to report the examples of this pattern only in anecdotal form.

A young man reports a dream which consists merely in a picture of female genitals with a penis. While discussing this dream in the analysis the next morning the patient develops an intense frontal headache which continues for several hours. Associations to this dream indicate as usual that the dream is a defense against the feminine wish to be attacked sexually, a wish which is associated with a fear of castration. It will be noted that the feminine wish and castration fear in this dream are both projected and energetically negated. The patient is merely observing a female genital which has a penis. Both the projection and the denial are achieved by the substitution of a visual image. Correlating with this intense fixation upon a visual image, the patient develops a headache.

A young professional woman was much disturbed by a conflict of loyalty between a male and female professional colleague, to both of whom she was much attached. The material at this time was obscure but later material made it plain that she was disturbed both by sexual desires towards the man and by wishes to harm the woman. In the midst of this conflict she devoted herself intensely for a few hours to study in preparation for a lecture which she was giving that afternoon. During this time she developed a violent frontal headache which continued during the lecture and was not relieved until some time the next day. In this instance we see an energetic urge to distract interest from an intense emotional conflict. The method in this case is to become absorbed in intellectual activity. The result is a headache.

A young woman dreams of seeing a woman who is fascinated and petrified by the sight of a huge negro man. The negro though motionless seems about to attack her. While discus-

sing this dream in the analysis the next day she develops an intense frontal headache. It will be noted that in this instance there is again a projection of the impulse to activity and an energetic denial of it.

It will be noted that the physiological mechanism implied in all these instances is one of attempting to distract energy from some conflict involving the need for energetic motor discharge by means of an intense intellectual preoccupation or visual fascination. In each of the two dreams cited we note that the implied activity has been completely 'frozen'. An immobilized visual image replaces the urge for violent activity. The emphasis upon visual excitation as contrasted with muscular activity is thus much greater than in the case of the anvil dream in which the patient is observing a scene of violent activity. In accordance with our principle, it seems consistent therefore that these patients should have developed severe headaches instead of muscular pains.

It is probable that in all of the instances cited so far we have pathological exaggerations of the normal alternation between thinking and activity that must play a very important rôle in the physiology of all kinds of behavior. By more careful and detailed study of such instances we might hope to work out the quantitative dynamic principles that regulate this normal oscillation between thinking and doing.

From our work at the Institute for Psychoanalysis we could cite a number of instances that seem to indicate the association of particular psychosomatic symptoms with rather specific patterns of distribution of physiological excitation in so far as these can be deduced from a reconstruction of the dream work.

One of the first examples was Alexander's (1935) demonstration of the frequency of dreams of unsatisfied desire for food in patients suffering from duodenal ulcer. It will be recalled that Alexander (1934) calls attention to the literature which cites physiological evidence of increased nocturnal gastric secretory activity in these cases as well as experimental production of ulcers by holding food just outside of an animal's reach.

In our study of the psychogenesis of asthma attacks (1939), we were struck by the reciprocal relations between asthma and crying. It appeared that the asthma attack was very often a sort of substitute for a suppressed cry. Interestingly enough the dreams of these patients very frequently represented the patient as talking. The talk usually had the meaning of an attempt to seek reconciliation by confession to a mother figure from whom some forbidden impulse threatened to estrange the dreamer. If the danger of estrangement of the mother figure were too great to be quieted in this way, the patient usually awoke with an attack of asthma. We note here again an example of the principle that the psychosomatic symptom involves the organ active at the time of frustration, in this case the respiratory apparatus involved in talking and crying.

I could cite still other examples but shall postpone discussion of them until the publication of the Chicago Institute studies upon which they are based.

In conclusion, I should like to bring these observations into relation with the wider field of psychosomatic research. At the present time an enormous amount of work is being done in the attempt to bridge the gap between the physiologist's detailed knowledge of the mechanisms of isolated reactions and the psychologist's attempts to work out the motivations that determine the larger patterns of behavior viewed as a whole. The two methods of research may be compared to two groups of workmen together engaged in the building of a tunnel under a river but starting from opposite ends. The physiologists are doing valiant work trying to piece together a detailed physiological mechanism in order to build up a synthetic picture of integrated behavior as a whole. Those of us at the psychological end, as in the present study, must seek to extract from our psychological material as many hints as possible as to the physiological mechanisms and dynamic principles involved in the translation of motives into action. Sometime in the future we hope to meet somewhere under the river.

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MICROPSIA

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The term micropsia is frequently used in the ophthalmological and neurological literature to describe a symptom which may occur in such conditions as choroiditis, retinitis, tumors of the temperosphenoidal lobe and hysteria. In the standard textbooks on diseases of the eyes, micropsia is defined as that condition in which objects appear removed in space and reduced in size. We shall see later that this definition is inadequate for the same phenomenon when it appears as a neurotic symptom. The occurrence of micropsia has been attributed to paresis of the accommodative function and to circulatory changes in the retinas or the optic brain centers.

In a brief article entitled A Psychoanalytical Explanation of Micropsia,[1] W. S. Inman writes about two boys who experienced this visual disturbance in connection with objects which symbolized the mother. Both patients had been nursed for excessive lengths of time and says Inman, 'whether oral fixation is responsible for every case of micropsia must be left to further investigation'. He expressed the opinion that 'transient micropsia is probably dependent upon some vagary of the intrinsic muscles of the eyes'. With this one exception no previous detailed investigation of hysterical micropsia has been reported in the literature.

In defining micropsia as a neurotic manifestation, I wish to emphasize the importance of the sensation of motion experienced during the occurrence of this symptom. As the patient stares at another person that person and subsequently all other objects in the visual field appear to be moving into the distance and simultaneously becoming smaller and smaller until everyone and everything is pin-point in size. When micropsia

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[1] Inman, W. S.: *A Psychoanalytical Explanation of Micropsia.* Int. J. Psa., XIX, 1938, pp. 226–228.

is a symptom of organic disease, objects at once appear to be at a greater distance and smaller than they are in reality.

The micropsia of a case to be described had never endured more than a few moments. This differentiated it from the micropsia of organic disease which is a more constant and persistent phenomenon. The fact that the patient continued to see objects as if they were far removed and markedly diminished in size even after she had closed her eyes also indicated that the micropsia was not due to an optical disorder but was an expression of her affects.

Confining the biographical data to those which relate to the origin and the significance of the micropsia in the life of the case, the patient was a twenty-eight-year-old married woman, whose husband was eleven years older than herself and whose infant daughter was three and a half months old at the time she came for treatment. After the birth of her daughter she began to suffer from a tightness in her throat which interfered with her speech because she was afraid that in talking she might choke to death. She also complained that her eyes burned, that they felt crossed and strained and that she was unable to look at another person when she was spoken to. She had lost interest in others, blamed herself for her illness, had severe insomnia, felt hopeless and depressed. These were the symptoms which brought her to treatment.

She was the second child in a group of four siblings, in a middle class family of German extraction. In contrast to her sister who was seventeen months older and who fought openly with the mother, the patient was an unusually well-behaved child, very inhibited in her speech, and unfavorably endowed compared with her superior sibling. Her mother had nursed her seventeen months and had sometimes remarked to friends and relatives that the patient was so fat because she had taken the milk which should have been given to her sister, the mother having had to wean the latter when she became pregnant with the patient. Her mother also related that the patient used to love to nurse and had often bitten

her breasts. This history of an unusually long nursing period corresponds with the two cases reported by Inman.

The patient had a brother five years her junior and a second brother who was born when she was ten years old. At the time of the latter event the patient felt ashamed of her mother, hated her father, was not allowed to come near the newly born child and was made to be very quiet about the house for several weeks afterwards. Unobserved by others, she secretly found her way to his crib and delighted in pinching him because, she said, he was so soft. The birth of this sibling had momentous effects because it revived the hostility she had experienced at the birth of her brother who was five years younger. Her death wish against her mother and brother was revived in her first dream in the analysis in which her husband and infant daughter were both dead. During her pregnancy she identified herself with her mother and her unborn child with her sibling, and she often pinched her abdomen as though to destroy the child whose birth had caused her such intense unhappiness. During her pregnancy, she often fantasied that her child would not live and that she and her husband would then take a pleasure trip together. She made no preparation for the birth of her daughter because she did not expect the child to live.

The micropsia first occurred when she was ten years old and a short time after her brother's birth. She recalled that it had happened at school. She was listening to a long drawn-out story by a woman teacher whom she hated because she favored the patient's playmate, a girl one year her junior. As she continued to stare at the teacher, the teacher and then all other objects in the room appeared to be moving into the distance until they seemed very far away and pin-point in size. The patient became frightened and overcame this distortion by looking at the dorsum of her right hand which she held near her eyes.

We observe three separate events in this experience. At first the hated mother figure was removed from the immediate surroundings to a point at which she almost vanished. The

patient then developed anxiety because of the possibility of losing her altogether and she brought her back by looking at a part of herself. It is noteworthy that whenever the micropsia recurred the patient invariably experienced the same feeling of fright and always overcame it by the same act of looking at the back of her right hand at close range.

After its onset at the age of ten, the micropsia occurred frequently and irregularly during the subsequent years and although the patient worried about it considerably she never spoke about it to anyone. This keeping it a secret was like her masturbation about which she also worried. Routine eye examinations by the school physician during those years never resulted in her being referred to an oculist and the patient herself always thought she had good eyesight. As she grew older the micropsia occurred less frequently and gradually she experienced it only at rare intervals.

During her analysis, a careful study of her sight, ocular muscle balance, intraocular tension, visual fields and retinas revealed no pathology. She had a low refractive error of insufficient degree to require correction.

The patient felt rejected by her mother who spent much time away from home and left most of the responsibility of raising her children to servants and relatives. As a child she envied the affectionate relationships which her playmates had with their mothers and her most bitter complaint was that when she talked to her mother she never seemed to pay attention to her: 'Her mind seemed to be far off; she would look into space. She appeared not to be interested in what I had to say.' During analysis the patient discovered that her own inability to look at other women when they were talking to her, and her lack of interest in what they were saying was an unconscious revenge for the hurts she had suffered as a child.

The patient's sister had a strabismus about which the mother was considerably concerned. When the patient became angry with her sister she often expressed her rage by looking cross-eyed and on these occasions her eyes subsequently felt strained. Her mother threatened her that she might develop the same

defect with which her sister was troubled. At the movies the patient became afraid for her own eyes when she saw a comedian whose entertaining ability depended principally upon his marked strabismus.

The patient's mother had a fiery temper and whenever she became angry with her or her sister the patient was especially terrified by the wild look in her eyes and the fierce expression of her countenance. Being inhibited in her speech and physically inferior to her sister, the patient was no match for her when they quarreled. She possessed one device, however, which often proved an effective weapon. She frightened her sister, as her mother had frightened her, by making horrible faces, growling like a bear and using her hands in a gesture of clawing. Upon looking into the mirror on those occasions, the patient herself was frightened and her fear was intensified by her mother's threat that her face might remain distorted that way. Similarly, whenever she experienced micropsia she always became afraid that her eyes might not resume their normal fuctioning.

Thus we see what an important rôle eyes had played in the life of this patient before the onset of the micropsia. Prior to the first appearance of the symptom, we observe that the patient often used her eyes to frighten her sister and that she had been repeatedly threatened by her mother that because she used her eyes as weapons they would be damaged. A belief of the patient that following the birth of her youngest brother the life went out of her mother's eyes and that they became expressionless and dull can only mean that she had turned her mother's threat that her eyes would lose their power, back upon the mother herself. A short time later she first experienced the micropsia.

In this symptom her oral impulses which had been repressed were displaced and discharged through her eyes. The original aim of the sadistic impulse in the micropsia was to kill with her stare. This was enacted through the subjective experience of banishing and diminishing the object almost to the point of extinction. During analysis the patient once remarked

that when she was able to verbalize her hatred she could feel the daggers shooting out of her eyes. Although her illusory removal of the other person was a mild form of death, it had another equally important and opposite meaning: it was also a defense against her destructiveness. In removing the object to a distance she protected it from being destroyed. She transferred it to a point of safety from her impulse. That her symptom represented this protection of the object was indicated by her statement that she sometimes experienced a momentary sense of relief from mounting tensions existing immediately preceding the occurrence of the micropsia.

In her psychosexual development her œdipal wishes were deeply tinged with oral destructiveness. She indulged in frequent clitoris masturbation from the age of eight until after marriage, and menstruation was not established until her seventeenth year. At the age of nine she often observed her father and uncle pinch the breasts and buttocks of her mother and aunt and she felt intensely aroused in her clitoris. When later she pinched her own child's cheeks or buttocks she experienced identical feelings of sexual excitement. We see that she identified herself with the pinching father and uncle. Pinching was a thinly disguised expression of her oral sadistic impulse and it was accompanied by strong erotic sensations.

The sharp ambivalence she manifested derived from the exceptionally long nursing period during which she had excessive gratification in sucking and biting. At a time when she should have been chewing and biting solid food her oral sadism was reinforced through the continued breast feeding. This ambivalence persisted in kissing which for her was accompanied by a fierce impulse to hurt that she found it necessary to restrain. This combination of hurting and protecting the object was characteristic of the micropsia.

During analysis she recalled her childhood disgust for warm milk and particularly for the skin of the milk which she sometimes inadvertently took into her mouth and which she said felt repellently soft. While recalling this she suddenly saw the nipple of her mother's breast, the lumps in hot cereal

which also had the same quality of softness as the nipple, and the skin of her husband's penis. She then became aware that her aversion to being kissed had been based upon the association of her husband's tongue and saliva to her mother's breast and milk. When this defense against her oral-erotic wishes had been uncovered she mentioned that when she saw beautifully curved finger nails on the hands of other women she wanted to suck them. These facts made it clear that the meaning of her difficulty in looking at another woman when she was spoken to was a defense against her desire to nurse. In these situations her eyes functioned as intaking organs and language had the significance of breast milk.

Unconsciously she identified herself with her father and her younger brother and in her relationships with men she clearly manifested the revengeful attitude so well described by Abraham. In late adolescence she felt ill at ease in the presence of boys and went about with those whom she regarded as weaker than herself. She found considerable satisfaction in enticing men and then denying them any intimacies. After a courtship of five years she married an older man who was a friend of her father. Prior to marriage she thought him much like her father but she later found him to be cold and critical of her like her mother. In her sexual relationships with him she had severe vaginismus, was utterly frigid, and occasionally hurt him by pinching his penis.

With the birth of her daughter she became incontinent of both fæces and urine, refused to nurse the baby and entrusted its care entirely to an aged nurse whom she identified with the elderly woman who had attended to each of her brothers during their infancy. In her identification with her own child she revealed the extent to which she had wished to replace each of her brothers at the time of their births. Somewhat later when it became necessary for her to take care of her child, she regarded her as a hated rival and could scarcely restrain her murderous impulses.

The patient dreamed that she was pulling her baby in a cart along a steep hillside in the cold and the rain. The

cart slipped and the baby rolled down the hill to the edge of a deep hole. The patient went to her and she was tiny and scrawny like a newly born sparrow without feathers. The patient did not like touching her because she dreaded she would flutter in her hand like a moth or butterfly. As the patient brought her back to the hillside again the baby resumed her normal size.

The dream was directly related to fondling her husband's penis before sleep with the thought that it was ugly. As her husband kissed her body she had looked on coldly and with disgust. She recalled that in her childhood her brother was so fascinated by the softness of his pet rabbit that he had accidentally squeezed it to death. She had always hated to look at dead sparrows or live baby sparrows. The coldness and rain in the dream are expressions of her hostility which is expressed more openly in the central theme. She not only rids herself of her child but depreciates it by giving it the characteristics of an ugly newly born sparrow which she equates with the hated phallus. In the dream the baby rolling away from her and becoming tiny in size is also what happened to persons and things in the micropsia. Bringing the child back to its normal size was like that part of her symptom in which she restored objects in the outside world to their normal proportions.

The micropsia recurred on one occasion during the analysis under the following circumstances: the patient was feeling angry towards a man because he was refusing to accept some ideas her husband was expounding. In an effort to outdo her husband she attempted to explain the problem more clearly but was equally unsuccessful. In that moment she felt exasperated with him and as she stared at him he appeared to be moving away from her. She said he did not diminish in size because she quickly interrupted the symptom by looking at the back of her right hand. She added, 'Had I kept staring long enough and hard enough without blinking an eye he and everything else in the room would have become infinitely

small and far removed. I used to let it go on for a while and see how far it would continue but as everything got tiny I became frightened.'

In the situation I have described we see that the symptom was immediately preceded by the identical feeling of helpless rage she had experienced as a child when she made horrible faces at her sister. With the micropsia she overcame this feeling of helplessness by magic, illusory mastery of the object and simultaneously she found expression for her rage through removing him from her immediate presence. Her statement that had she 'kept staring long enough and hard enough without blinking an eye, he and everything in the room would have become infinitely small and far removed', gives some indication of the feeling of omnipotence she possessed in her eyes with which to alter painful situations in the outside world to suit her own needs. Her remark that she 'used to let it go on for a while to see how far it would continue' shows what pleasure she must have experienced in observing her own magic device.

From the evidence, it is concluded that micropsia is in this instance a conversion symptom originating in the prolongation of the nursing period and in a subsequent inability adequately to express intense aggressions. The intensification of her oral sadism required the formation of equally powerful defenses resulting in severe inhibitions of speech.

The mother's ability to frighten the patient with her eyes provided the pattern. Following these experiences the patient's eyes began to function as outlets for aggressions which had previously been blocked at the oral level. When the patient looked cross-eyed and made horrible faces her mother threatened her that her eyes would be damaged. The birth of her brother with its intensification of her hatred of her mother and its reinforcement of her oral desires was followed by the appearance of the micropsia. The symptom represented a compromise between her aggressive tendencies and the defense against them. The object moving into the distance

and becoming smaller signified both the effect of her aggression and the removal of the object beyond the carrying power of her destructiveness. Frightened by this removal she had to make another magic gesture. By looking at the back of her hand she restored the loved and hated object whom she feared she would otherwise lose entirely.

THE SUCCESSFUL TREATMENT OF A CASE OF ACUTE HYSTERICAL DEPRESSION BY A RETURN UNDER HYPNOSIS TO A CRITICAL PHASE OF CHILDHOOD

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Events Which Led to the Attempt to Treat a Depression By Hypnosis

An unusually capable twenty-three-year-old woman had been employed in a mental hospital for several months. Towards the end of this period she developed a progressively deepening depression. Later it became known that she had continued to discharge her duties fairly well for some weeks after a certain upsetting event; but that as time passed she had become increasingly disinterested and ineffectual in her work, slowly discontinuing all social relationships, and spending more and more time secluded in her room. At this point in her illness she ate only in response to her roommate's pleading, sobbed much of the time, occasionally expressed a wish to die, and became blocked and inhibited in speech whenever any effort was made to question her about her difficulties. During the latter part of this phase, the patient's symptoms became so acute that her relatives and friends sought psychiatric help.

The patient was seen by several psychiatrists, some of whom diagnosed her condition as the depressive phase of a manic depressive psychosis. A psychoanalyst and one of the authors, Dr. Erickson, believed it to be an acute reactive depression. Later evidence, which became available only as the story developed, indicated that it was a typical 'hysterical depression', that is, a depressive reaction growing out of a definite hysterical episode.

Several consultants were in favor of commitment. To this, however, the family of the patient would not consent, insisting that some form of active psychotherapy be at least attempted.

Accordingly, sympathetic and persuasive encouragement was tried. The patient responded to this sufficiently to appear slightly less depressed, and to return to her work in a feeble and rather ineffectual fashion; but she remained unable to discuss her problem.

This slight amelioration of her symptoms was sufficiently encouraging to warrant further efforts, yet was far from sufficient to free her from the danger of a relapse into deeper suicidal depression. Furthermore, the threat of commitment still hung over her head; therefore, with many misgivings the suggestion was made that she attempt psychoanalytic treatment. She showed some interest in this idea, and despite the fact that it is unusual to attempt analysis in the midst of a retarded depression, for a period of about a month she was encouraged to make daily visits to an analytically trained psychiatrist.

During this month, except for the fact that the analytic hour seemed to help the patient to make a better adjustment during the rest of the day, she made little progress, produced no free associations, related only a few fragmentary parts of her story, and usually spent the hour in depressed silence with occasional futile efforts to say something, or in sobbing as she declared that she did not know what awful thing was wrong with her or what awful thing had happened to her. Towards the end of the month she began to show signs of relapsing into an acute depression of psychotic intensity so that commitment seemed imperative.

In spite of these discouraging experiences, the family again asked that before resorting to commitment some other therapeutic measure be attempted. The suggestion that hypnotic therapy might be of value was accepted by her relatives, and plans were made for this *without the patient's knowledge.* At this point the patient's problem was referred to Dr. Erickson with the following story which had been pieced together by the various psychiatrists from the accounts of the patient's roommate, of her relatives, of a man in the case, and in small part, of the patient herself.

Clinical History

The patient was the only daughter in a stern, rigid, and moralistic family. Her mother, of whom she always stood in awe, had died when the patient was thirteen years old. This had had the effect of limiting somewhat her social life, but she had an unusually close friendship with a neighbor's daughter of her own age. This friendship had continued uneventfully from childhood until the patient was twenty years old, three years before the date of the patient's illness.

At that time the two girls had made the acquaintance of an attractive young man with whom both had fallen in love. Impartial towards them at first, the young man gradually showed his preference for the other girl, and presently married her. The patient responded to this with definite disappointment and regret but quickly made an adjustment which seemed at the time to be unusually 'normal', but which in view of later developments must be viewed with some suspicion. She continued her friendship with the couple, developed transitory interests in other men, and seemed to have forgotten all feelings of love for her friend's husband.

A year after the marriage, the young wife died of pneumonia. At the loss of her friend the patient showed a wholly natural grief and sorrow. Almost immediately thereafter, the young widower moved to another section of the country, and for a time dropped out of the patient's life completely. Approximately a year later he returned and by chance met the patient. Therepon their former friendship was resumed and they began to see each other with increasing frequency.

Soon the patient confided to her roommate that she was 'thinking seriously' about this man, and admitted that she was very much in love with him. Her behavior on returning from her outings with him was described by the roommate and by others as 'thrilled to the skies', 'happy and joyous', and 'so much in love she walks on air'.

One evening, after some months, she returned early and alone. She was sobbing and her dress was stained with vomitus. To her roommate's anxious inquiries, the patient answered

only with fragmentary words about being sick, nauseated, filthy, nasty and degraded. She said that love was hateful, disgusting, filthy and terrible, and she declared that she was not fit to live, that she did not want to live, and that there was nothing worth while or decent in life.

When asked if the man had done anything to her, she began to retch, renewed her sobs, begged to be left alone, and refused to permit medical aid to be summoned. Finally she yielded to persuasion and went to bed.

The next morning she seemed fairly well, although rather unhappy. She ate her breakfast, but when a friend who knew nothing of these events casually asked about the previous evening's engagement, the patient became violently nauseated, lost her breakfast, and rushed precipitously to her room. There she remained in bed the rest of the day, sobbing, uncommunicative, uncoöperative with a physician who saw her, essentially repeating the behavior of the previous evening.

During that day the man tried to call on her. This precipitated another spell of vomiting; she refused to see him. She explained to her roommate that the man was 'all right', but that she was nasty, filthy, disgusting and sickening, and that she would rather kill herself than ever see that man again. No additional information could be obtained from her. Thereafter, a telephone call or a letter from the man, or even the mention of his name, and finally even a casual remark by her associates about their own social contacts with men, would precipitate nausea, vomiting and acute depression.

To a psychiatrist, the man stated that on that evening they had gone for a drive and had stopped to view a sunset. Their conversation had become serious and he had told her of his love for her and of his desire to marry her. This confession he had long wanted to make, but had refrained even from hinting at it because of the recency of his wife's death and his knowledge of the depth and intimacy of the friendship that had existed between the two girls. As he had completed his confession, he had realized from the expression on her face that she reciprocated his feelings, and he had leaned over to

kiss her. Immediately she had attempted to fend him off, had vomited over him in an almost projectile fashion, and had become 'just plain hysterical'. She had sobbed, cried, shuddered, and uttered the words 'nasty', 'filthy', and 'degrading'. By these words the man had thought she referred to her vomiting. She refused to let him take her home, seemed unable to talk to him except to tell him that she must never see him again and to declare that there was nothing decent in life. Then she had rushed frantically away.

Subsequently, all efforts on the part of friends or physicians to talk to the patient about these events had served only to accentuate the symptoms and to evoke fresh manifestations.

Preparation for an Indirect Hypnotic Investigation

Many hints from this story induced the investigator not to attempt to hypnotize the patient simply and directly. In the first place, there was the fact that she had rejected every overt sexual word or deed with violent vomiting, and with a paralyzing depression which practically carried her out of contact with those who had attempted to help her. She rejected the man so completely that she could not hear or mention his name without vomiting; and this reaction to men had become so diffused that she could not accept the ministrations of male physicians, but reacted as though they meant to her the same kind of threat her suitor had represented. She had been able to accept him only in a spiritualized and distant courtship, or when she was protected by the presence of her friends. It was evident that she would far too greatly fear direct hypnosis to submit to it.

She was moreover too deeply entrenched in the refuge of illness to fight energetically for health. She had no resources with which to struggle against her anxiety and depression, but at any signal collapsed deeper into illness. This gave warning that in the preliminary phases of treatment one would have to work completely without her coöperation, either conscious or unconscious, without raising the least flurry of anxiety, without making a single frightening or disturbing allusion to her

trouble, if possible without her even knowing that she was being inducted into treatment; and most important of all, without her feeling that the therapist (the hypnotist) was directing his conduct towards her at all. Whatever was going on in her presence must seem to her to relate to someone else. Only in this way could the treatment be undertaken with any hope of success. It should be recalled that even the passive, quiet, wordless, almost unseen presence of an analyst had been too great an aggression for the patient to accept, an intolerable erotic challenge, with the result that after a month she had sunk deeper into depression.

Accordingly, arrangements were made to have the patient's roommate confide to the patient that for some time she had been receiving hypnotic psychotherapy. Two days later the psychoanalyst approached the patient and asked her, as a favor to him in return for his efforts on her behalf, to act as a chaperone for her roommate in her regular hypnotic session with Dr. Erickson. This request he justified by the explanation that she was the only suitable chaperone who knew about her roommate's treatment, and that the nurse who usually chaperoned the treatment was unavoidably absent. The patient consented in a disinterested and listless fashion, whereupon he casually suggested that she be attentive to the hypnotic work since she herself might sometime want to try it.

By asking the patient to do this as a favor for him, the analyst put her in an active, giving rôle. By suggesting to her that she listen carefully because she herself might want similar help some time, he eliminated any immediate threat, at the same time suggesting that in some undefined future she might find it useful to turn to the hypnotist for therapy.[1]

[1] These two points are of special interest to analysts who are accustomed to demand of their patients an awareness of their illnesses and of the need for treatment, and an acceptance of the therapeutic relationship to the analyst. While this is a valid basis for therapeutic work with many of the neuroses it is an impossible goal in dealing with many neurotic characters and with those neuroses which are accompanied by severe affective disturbances, and with psychoses. The analyst who becomes too completely habituated to his own method may delude himself with the idea that his passivity is pacifying, and

The First Hypnotic Session

Upon entering the office, the two girls were seated in adjacent chairs and a prolonged, tedious, and laborious series of suggestions were given to the roommate who soon developed an excellent trance, thereby setting an effective example for the intended patient. During the course of this trance, suggestions were given to the roommate in such a way that by imperceptible degrees they were accepted by the patient as applying to her. The two girls were seated not far apart in identical chairs, and in such a manner that they adopted more or less similar postures as they faced the hypnotist; also they were so placed that inconspicuously the hypnotist could observe either or both of them continuously. In this way it was possible to give a suggestion to the roommate that she inhale or exhale more deeply, so timing the suggestion as to coincide with the patient's respiratory movements. By repeating this carefully many times, it was possible finally to see that any suggestion given to the roommate with regard to her respiration was automatically performed by the patient as well. Similarly, the patient having been observed placing her hand on her thigh, the suggestion was given to the roommate that she place her hand upon her thigh and that she should feel it resting there. Such maneuvers gradually and cumulatively brought the patient into a close identification with her roommate, so that gradually anything said to the roommate applied to the patient as well.

Interspersed with this were other maneuvers. For instance, the hypnotist would turn to the patient and say casually, 'I hope you are not getting too tired waiting'. In subsequent suggestions to the roommate that she was becoming tired, the patient herself would thereupon feel increasing fatigue without any realization that this was because of a suggestion which had been given to her. Gradually, it then became possible for the hypnotist to make suggestions to the roommate, while

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may overlook the extent to which it may be an assault in terms of the patient's unconscious emotional reactions. The approach described above, therefore, is an illustration of a method whereby, under appropriate circumstances, these difficulties can be circumvented.

looking directly at the patient, thus creating in the patient an impulse to respond, just as anyone feels when someone looks at one, while addressing a question or a comment to another person.

At the expiration of an hour and a half, the patient fell into a deep trance.

Several things were done to insure her coöperation in this trance and its continuance, and to make sure that there would be opportunities to use hypnotic treatment in the future. In the first place, the patient was told gently that she was in a hypnotic trance. She was reassured that the hypnotist would do nothing that she was unwilling to have him do, and that therefore there was no need for a chaperone. She was told that she could disrupt the trance if the hypnotist should offend her. Then she was told to continue to sleep deeply for an indefinite time, listening to and obeying only every legitimate command given her by the hypnotist. Thus she was given the reassuring but illusory feeling that she had a free choice. Care was taken to make sure that she had a friendly feeling towards the hypnotist, and for future purposes a promise was secured from her to develop a deep trance at any future time for any legitimate purpose. These preliminaries were time consuming but they were vitally necessary for safeguarding and facilitating the work to be done.

It was obvious that the patient's problems centered around emotions so violent that any therapeutic exploration would have to be carried out in some wholly 'safe' fashion without provoking the least trace of guilt or fear. Such 'safe exploration' meant dealing with everything in such a way that the patient could escape all painful implications. The first maneuver was to lead the patient back to a childhood devoid of childhood pain.

Accordingly, emphatic instructions were given to the patient 'to forget absolutely and completely many things', carefully omitting to specify just what was to be forgotten. Thus the patient and the hypnotist entered into a tacit agreement that some things were best forgotten—that is, best repressed. Per-

mission also was thereby given to the patient to repress them without naming them. The exploratory process which lay ahead would be facilitated by this permission to repress the more painful things, since automatically it would be applied to those which were most troublesome.[2]

Next, the patient was systematically subjected to a gradual disorientation for time and place, and then gradually was reoriented to a vaguely defined period in childhood lying somewhere between the ages of ten and thirteen. The technique used is described in some detail in studies on the hypnotic induction of color blindness and of hypnotic deafness *(1, 2)*. The hypnotist suggests first, a state of general confusion as to the exact day, carrying this over step by step to include the week, the month, and the year. Then this is elaborated towards an intensification of a desire to recall certain unspecified things which had occurred in previous years which also are left indeterminate. The process is a slow one and involves jumping from one confusing idea to another until out of the state of general confusion the patient develops an intense need for some definite and reassuring feeling of certainty about something, whereupon he becomes only too glad to accept definite reassurance and definite commands.

In reorienting the patient towards the age period between ten and thirteen, the hypnotist was careful to be extremely dogmatic in tone of voice, but equally vague and indefinite as to his precise meaning. The suggestions were given to the patient as though talking to someone else rather than directly to her. She was not told that she herself had to seize upon some meaningful event in those three years.

The years from ten to thirteen were chosen with the idea that they just preceded her mother's death, and that they must have included the period of onset of her menstruation and therefore have meant the critical turning point in her gen-

[2] Here again is an interesting and significant departure from analytic technique, in which the implicit and sometimes explicit challenge is to break through every repression. The rigidity with which this axiom of analytic technique is applied may account for some analytic failures, and also may be an example of conflict between research and therapeutic purposes.

eral emotional life and in her psychosexual development. Since nothing was known in detail about her life, the exact period of time to which she would finally become reoriented was left to the force of her own experiences.

She was at no time asked to name and identify specifically the age to which she became reoriented in the trance. By allowing her to avoid this specific detail, she was compelled to do something more important, namely, to speak in general terms of the total experience which those years had meant.[3]

Presently in her trance the patient showed by the childishness of her posture and manner, as well as by the childishness of her replies to casual remarks, that she had really regressed to a juvenile level of behavior. She was then told emphati-

[3] The search backwards towards reliving an earlier period in the life of a hypnotic subject occurs in either of two ways. First there can be a 'regression' in terms of what the subject as an adult believes, understands, remembers or imagines about that earlier period of his life. In this form of 'regression' the subject's behavior will be a half conscious dramatization of his present understanding of that previous time, and he will behave as he believes would be suitable for him as a child of the suggested age level. The other type of 'regression' is far different in character and significance. It requires an actual revivification of the patterns of behavior of the suggested earlier period of life in terms only of what actually belonged there. It is not a 'regression' through the use of current memories, recollections or reconstructions of a bygone day. The present itself and all subsequent life and experience are as though they were blotted out. Consequently in this second type of regression, the hypnotist and the hypnotic situation, as well as many other things, become anachronisms and nonexistent. In addition to the difficulties inherent in keeping hypnotic control over a total situation, this 'deletion' of the hypnotist creates an additional difficulty. It is not easy for the hypnotist to enter into conversation with someone who will not meet him until ten years hence. This difficulty is overcome by transforming the hypnotist into someone known to the patient during the earlier period, by suggesting that he is 'someone whom you know and like, and trust and talk to'. Usually a teacher, an uncle, a neighbor, some definite or indefinite figure belonging to the desired age period is selected automatically by the subject's unconscious. Such a transformation of the hypnotist makes it possible to maintain contact with the subject in the face of the anachronism mentioned above. Unfortunately many investigators of 'hypnotic regression' have accepted as valid that type of 'regression' which is based upon current conceptions of the past; and they have not gone on to the type of true regression in which the hypnotic situation itself ceases and the subject is plunged directly into the chronological past.

cally, 'You know many things now, things you never can forget no matter how old you grow, and you are going to tell me those things now just as soon as I tell you what I'm talking about'. These instructions were repeated over and over again with admonitions to obey them, to understand them fully, to be prepared to carry them out exactly as told, and she was urged to express and affirm her intention to carry through all of these suggestions. This was continued until her general behavior seemed to say, 'Well, for what are we waiting? I'm ready.'

She was told to relate everything that she knew about sex, especially in connection with menstruation, everything and anything that she had learned or been told about sex during the general period of this hypnotically reëstablished but purposely undefined period in her childhood. It is fair to call this an 'undefined period in her childhood' because three or four years is indeed a long time to a child, and from among the many and diverse experiences of those years she was at liberty to select those things which were of outstanding importance. Had she been confined to a more restricted span of time she could have chosen inconspicuous items. Leaving her to select from within a certain broad but critical period in her life forced her to choose the important and painful items.

Up to this point the hypnotic procedure had been systematically planned, with the expectation that any further procedure would depend upon the results of these preliminary maneuvers.

To these instructions the patient reacted with some fright. Then in a tense and childlike fashion she proceeded obediently to talk in brief disconnected sentences, phrases and words. Her remarks related to sexual activity, although in the instructions given to her emphasis had been laid not upon intercourse but upon menstruation. The following constitutes an adequate account:

> 'My mother told me all about that. It's nasty. Girls mustn't let boys do anything to them. Not ever. Not nice. Nice girls never do. Only bad girls. *It would make mother*

sick.[4] Bad girls are disgusting. I wouldn't do it. You mustn't let them touch you. You will get nasty feelings. You mustn't let them touch you. You will get nasty feelings. You mustn't touch yourself. Nasty. Mother told me never, never, and I won't. Must be careful. Must go good. Awful things happen if you aren't careful. Then you can't do anything. It's too late. I'm going to do like mother says. She wouldn't love me if I didn't.'

Many of the remarks were repeated many times in essentially identical wordings. Some were uttered only once or twice. She was allowed to continue her recitation until no new material was forthcoming, except the one additional item that this moralistic lecture had been given by the mother on several occasions.

No attempt was made to introduce any questions while she was talking, but when she had ceased she was asked, 'Why does your mother tell you these many things?'

'So I'll *always* be a good girl', was the simple, earnest, childlike reply.[5]

Although it was clear, almost from the start, that the patient's passive and submissive dependence upon the mother's commands would have to be broken, it was equally evident that the image of the dead mother played a rôle in her life which overshadowed that of any living person and that this idolized superego figure could not be dislodged from its position by any direct frontal attack. For this reason, the hypnotist's stratagem was to adopt a point of view as nearly identical with the mother

[4] The phrase, 'It would make mother sick', may have had much to do with her illness: Mother had had intercourse and died. Her friend, who was a mother substitute, had intercourse and died. The same thing was about to happen to the patient. Mother has said it and it must be true. It is a child's passive acceptance of logic from the image with which it has become identified.

[5] Here is an important bit of profound unconscious psychological wisdom. The commands had been repeated incessantly in the patient's mind, whether or not in reality they had been repeated as incessantly by the mother. This repetition which is the essence of all neurosis (3) must occur because of the resurgent instinctual demands. Hence the patient indicates in the word 'always', her continuing secret insurrection against a continuing prohibition, and therefore her ever present state of fear.

as he could. He had first to identify himself entirely with this mother image. Only at the end did he dare to introduce a hint of any qualifying reservations. Therefore he began by giving the patient immediate and emphatic assurance: 'Of course you *always* will be a good girl'. Then in a manner which was in harmony with the mother's stern, rigid, moralistic, and forbidding attitudes (as judged from the patient's manner and words), each idea attributed to the mother was carefully reviewed in the same terms, and each was earnestly approved. In addition, the patient was admonished urgently to be glad that her mother had already told her so many of those important things that every mother really should tell her little girl. Finally, she was instructed to 'remember telling me about all of these things, because I'm going to have you tell me about them again some other time'.

The patient was gradually and systematically reoriented in terms of her current age and situation in life, thereby reëstablishing the original hypnotic trance. However, the earlier instructions to 'forget many things', were still in effect, and an amnesia was induced and maintained for all of the events of the hypnotically induced state of regression. This was done in order to soften the transition from those early memories to the present because of the intense conflict which existed between the early maternal commands and her current impulses.

She was prepared for the next step, however, by being told that she would shortly be awakened from her trance and that then she would be asked some questions about her childhood which she was to answer fully. To have asked her in her ordinary waking state about her sexual instructions would have been merely to repeat the severe aggressions of all of her previous experiences with psychiatrists; but by telling her during her trance that questions about her childhood would be asked, she was prepared to take a passive intellectual attitude towards the demand, and to obey it without consciously admitting its connection with her present problems.

As a further preparation for the next step, she was told that

the nature of the questions to be asked of her would not be explained to her until she had awakened, and that until then it would suffice for her to know merely that the questions would deal with her childhood. Here again the hypnotist was governed by the basic principle of making all commands as general and nonspecific as possible, leaving it to the subject's own emotional needs to focus his remarks.

Finally, technical suggestions were given to the patient to the effect that she should allow herself to be hypnotized again, that she should go into a sound and deep trance, that if she had any resistances towards such a trance she would make the hypnotist aware of it *after* the trance had developed, whereupon she could then decide whether or not to continue in the trance. The purpose of these suggestions was merely to make certain that the patient would again allow herself to be hypnotized with full confidence that she could if she chose disrupt the trance at any time. This illusion of self-determination made it certain that the hypnotist would be able to swing the patient into a trance. Once in that condition, he was confident that he could keep her there until his therapeutic aims had been achieved.

Upon awakening, the patient showed no awareness of having been in a trance. She complained of feeling tired and remarked spontaneously that perhaps hypnosis might help her since it seemed to be helping her roommate. Purposely, no reply was made to this. Instead, she was asked abruptly, 'Will you please tell me everything you can about any special instructions concerning sexual matters that your mother may have given you when you were a little girl?'.

After a show of hesitation and reluctance, the patient began in a low voice and in a manner of rigid primness to repeat essentially the same story that she had told in the earlier regressive trance state, except that this time she employed a stilted, adult vocabulary and sentence structure, and made much mention of her mother. Her account was essentially as follows:

'My mother gave me very careful instruction on many occasions about the time I began to menstruate. Mother impressed upon me many times the importance of every nice girl protecting herself from undesirable associations and experiences. Mother made me realize how nauseating, filthy and disgusting sex can be. Mother made me realize the degraded character of anybody who indulges in sex. I appreciate my mother's careful instruction of me when I was just a little girl.'

She made no effort to elaborate on any of these remarks, and was obviously eager to dismiss the topic. When she had concluded her account of her mother's teachings, they were systematically restated to her without any comment or criticism. Instead they were given full and earnest approval, and she was told that she should be most grateful that her mother had taken advantage of every opportunity to tell her little daughter those things every little child should know and should begin to understand in childhood.

Following this an appointment was made for another interview a week hence and she was hastily dismissed.

During the course of the following week, no new reactions were noted in the patient by her roommate and the general trend of her depressive behavior continued unchanged.

The Second Hypnotic Trance

At the second appointment, the patient readily developed a deep trance and at once was instructed to recall completely and in chronological order the events of the previous session. She was asked to review them in her mind silently, and then to recount them aloud slowly and thoughtfully but without any elaboration.

Such silent review of a hypnotically repressed experience is a necessary preparation. It insures completeness of the final recall. It avoids uneven emphasis on separate elements in the recollection and distorted emphasis which the subject subsequently would feel the need of defending. It permits an

initial recall in silence without any feeling that in remembering facts the subject is also betraying them to someone else. This facilitates the reassembling of painful elements in the subject's memories. Finally, when the subject is asked to tell aloud that which has just been thought through in silence, it becomes a recounting of mere thoughts and memories, rather than the more painful recounting of actual events. This also helps to lessen the emotional barriers against communicating with the hypnotist.

As the patient completed this task, her attention again was drawn to the fact that her mother had lectured her repeatedly. Then she was asked, 'How old were you when your mother died?', to which she replied, 'When I was thirteen'. Immediately the comment was made with quiet emphasis, 'Had your mother lived longer she would have talked to you many more times to give you advice; but since she died when you were only thirteen, she could not complete that task and so it became your task to complete it without her help'.

Without giving the patient any opportunity either to accept this comment or to reject it, or indeed to react to it in any way, she quickly was switched to something else by asking her to give an account of the events which had occurred immediately after she had awakened from her first trance. As she completed the account, her attention was drawn to the repetitive character of her mother's lectures, and the same careful comment was made on the unfinished character of her mother's work.

It will be recalled that in the first day of hypnotic work the patient was brought back to an early period in her childhood and in this pseudoregression was asked to give an account of the sexual instructions her mother had given her. Then through a series of intermediate transitional states she was wakened, and in her waking state was asked to give an account of the same instructions, but with an amnesia for the fact that she had already told any of this to the hypnotist. In the second hypnotic treatment up to this point, the patient was promptly

hypnotized and the posthypnotic amnesia for the first hypnotic experience was lifted so that she could recall all of the events of her first trance. Then she was asked to review the material which she had discussed immediately after awakening from the first trance, in short, her conscious memories of her mother's puritanical instructions. By reviewing in a trance both the events of her previous trance and the events that had occurred immediately on her waking from this trance, a direct link was established between the childhood ideas and affects and those of the previous week's adult experience. Thus the two could be contrasted and compared from her adult point of view.

The patient then was reoriented to the same period of early childhood. She was reminded of the account she had given before and was asked to repeat it. When she had done so, in terms essentially identical with those she had used in her original account, similar approving remarks were made, but this time so worded as to emphasize sharply the fact that these lectures had all been given to her in her childhood. When this seemed to be impressed upon her adequately, the suggestion was made quietly that as she grew older, her mother would have to give her additional advice, since things change as one grows older. This idea was repeated over and over, always in conjunction with the additional suggestion that she might well wonder what other things her mother would tell her as she grew older.

Immediately after this last suggestion, the patient was brought back from her pseudochildhood to an ordinary trance state. She was asked to repeat her account of the remarks she had made in the waking state. She was urged to take special care not to confuse the words she had used when fully awake with the words of the account she had given in the first pseudochildhood trance state, even though the ideas expressed were essentially the same, and even though she had both accounts freshly in her mind. This request constituted a permission to remember now in an ordinary trance the events of the second pseudochildhood trance, since this had been merely a repetition of the first, but the fact that there had been a second trance

of this kind would not be recalled. Instead, the two trances would be blended into a single experience.

As before, the purpose of these devices was to bring gradually together the child's and the adult's points of view. Into her childhood perspective an element of expectation and of wondering had been introduced by the comment that as she grew older her mother would have had more to teach her. This now, was ready to be brought to bear upon the adult version of her mother's instructions which she had also given.

The blending of the two experiences served an additional technical purpose. In the first place, repetitions are necessary under hypnosis, just as they are in dream analysis or in the recounting of experiences by patients under analysis in general. Without repetitions one cannot be sure that all of the material is brought to expression; moreover, allowing the subject under hypnosis to recall both the original version and the various repetitions as though they were a single occasion, actually gives the subject something to hold back, namely, the fact that there were two or more experiences. This seems to satisfy the subject's need to withhold something, by giving him something unimportant to withhold in return for the important fact which is divulged. This the hypnotist can well afford to do, just as one can allow a baby to refuse to give up a rattle when he has already given up the butcher's knife. The baby is satisfied and so is the parent.

As the patient concluded this task, her attention was drawn again to the period of her life in which her mother's lectures had been given, the repetitions of these lectures, their incompleteness, the unfinished task left to a little girl by her mother's death, and the necessity to speak to a child in simple and unqualified language before she is old enough for more complex adult understanding. Every effort was made to impress each of these specific points upon her, but always by the use of terms as general as possible.

Without giving the patient an opportunity to develop or elaborate these points, the suggestion was made that she might well begin the hitherto unrealized and unrecognized task of

continuing for herself the course of sexual instruction which her mother had begun but had been unable to finish because of her death. She was urged that she might best begin this unfinished task by speculating earnestly and seriously upon what advice her mother would have given her during the years intervening between childhood and adolescence, and between adolescence and adult womanhood. As she accepted this suggestion, it was amplified by additional instructions to take into consideration all intellectual and emotional aspects, all such things as physical, psychological and emotional changes, development and growth, and most important to give full consideration to the ultimate reasonable goals of an adult woman, and to do so completely, fully, freely and without fail, and to elaborate each idea in full accord with the facts appropriate to herself.

Immediately after this instruction was given, the patient was told that upon awakening she should repeat all of the various accounts she had given in this hypnotic session, preferably in their chronological order, or else, if she chose, in any other comprehensive form which she preferred. Thereupon she was awakened.

The patient's waking account was decidedly brief. She slowly combined everything which she had said into a single, concise story. Significantly, she spoke in the past tense: 'My mother attempted to give me an understanding of sex. She tried to give it to me in a way that a child such as I was could understand. She impressed upon me the seriousness of sex; also, the importance of having nothing to do with it. She made it very clear to me as a child.'

This account was given with long pauses between each sentence, as though thinking profoundly. She interrupted herself several times to comment on her mother's death, and on the incompleteness of her instruction, and to remark that had her mother lived more things would have been said. Repeatedly she said, as if to herself, 'I wonder how mother would have told me the things I should know now'.

The examiner seized upon this last remark as a point for

terminating the session and the patient was dismissed hastily. No attempt was made to guide her thoughts beyond the urgent instruction to speculate freely upon the things her mother would have told her and which she now needed to know. She was told to return in one week.

During this week the patient showed marked improvement. Her roommate reported 'some crying, but of a different kind', and none of the previous depressed behavior. The patient seemed rather to be profoundly self-absorbed, absent-minded and puzzled; and much of the time she wore a thoughtful and sometimes bewildered expression. No attempt was made to establish any contact with the patient during the week.

Third Hypnotic Session

Promptly upon her arrival for the third session, the patient was hypnotized and instructed to review rapidly and silently within her own mind all of the events of the two previous sessions, to recall the instructions and suggestions which had been given to her and the responses which she had made, to include in her review any new attitudes which she might have developed and to give full and free rein to her thinking, and finally to summarize aloud her ideas and conclusions as she proceeded with this task.

Slowly and thoughtfully, but with an appearance of ease and comfort, the patient proceeded to review these events freely, briefly, and with no assistance. Her final statement summarized her performance most adequately:

> 'You might say that mother tried to tell me the things I needed to know, that she would have told me how to take care of myself happily and how to look forward confidently to the time when I could do those things appropriate to my age, have a husband and a home and be a woman who has grown up.'

The patient was asked to repeat this review in greater detail, in order to be sure that towards both her childhood and adult years she had achieved suitable adult attitudes. As these instructions were repeatedly slowly and emphatically, the

patient became profoundly absorbed in thought, and, after a short while, turned with an alert, attentive expression, as if awaiting the next step.

Instruction was given that when she awoke she was to have a complete amnesia for all three sessions, including even the fact that she had been hypnotized, with the exception that she would be able to recall her first stilted, prim, waking account. This amnesia was to include any new and satisfying understanding she had come to possess. She was told further that upon awakening she would be given a systematic review of her sex instruction as the hypnotist had learned about these matters from her, but that because of the all-inclusive amnesia this review would seem to her to be a hypothetical construction of probabilities built by the hypnotist upon that first waking account. As this occurred, she was to listen with intense interest and ever growing understanding. She would find truths and meanings and applications understandable only to her in whatever was said and, as those continued and developed, she would acquire a capacity to interpret, to apply and to recognize them as actually belonging to her, and to do so far beyond any capacity that the hypnotist might have to understand.

At first glance, it would seem strange to suggest repression of insight as one of the culminating steps in a therapeutic procedure. In the first place, it implies that much of the affective insight may either remain or again become unconscious without lessening its therapeutic value. Secondly, it protects the subject from the disturbing feeling that anyone else knows the things about her which she now knows, but which she wishes to keep to herself; hence the importance of the suggestion that she would understand far more than the hypnotist. Thirdly, by looking upon the material as a purely hypothetical construction of probabilities by the hypnotist, the patient was provided with an opportunity to recover insight gradually in a slowly progressive fashion as she tested this hypothetical structure. Had the same material been presented to her as definite and unquestionable facts, she might again have developed sudden repressions with a spontaneous loss of all insight. If

that occurred, the investigation would have had to be undertaken afresh. On the other hand, where a certain measure of repression is ordered by the hypnotist, it remains under his control, because what the hypnotist suppresses he can recover at will. Thus her degree of insight remained under full and complete control by the hypnotist, so that he could at any time give the patient full insight, or prepare her for it again. Finally, by depriving the patient temporarily of her new and gratifying insight, a certain unconscious eagerness and need for further knowledge was developed which assisted in the ultimate recovery of full insight.

When these instructions had been repeated sufficiently to effect a full understanding, the patient was awakened with an amnesia for all events except the stilted prim account which she had given at the end of the first therapeutic session. Reminding her of that account the hypnotist offered to speculate upon the probable nature and development of the sex instructions which she had been given. He proceeded to review all the material she had furnished in general terms that permitted her to apply them freely to her own experiences.

Thus the patient was given a general review of the development of all of the primary and secondary sexual characteristics: the phenomenon of menstruation, the appearance of pubic and axillary hair, the development of her breasts, the probable interest in the growth of her nipples, the first wearing of a brassiere, the possibilities that boys had noticed her developing figure and that some of them may have slapped her freshly, and the like. Each was named in rapid succession without placing emphasis on any individual item. This was followed by a discussion of modesty, of the first feelings of sexual awareness, of autoerotic feelings, of the ideas of love in puberty and adolescence, of the possible ideas of where babies came from. Thus without any specific data, a wide variety of ideas and typical experiences were covered by name. After this, general statements were made as to the speculations that might have passed through her mind at one time or another. This again was done slowly and always in vague general terms, so that she

could make a comprehensive and extensive personal application of these remarks.

Shortly after this procedure was begun the patient responded by a show of interest and with every outward manifestation of insight and of understanding. At the conclusion the patient declared simply, 'You know, I can understand what has been wrong with me, but I'm in a hurry now and I will tell you tomorrow'.

This was the patient's first acknowledgment that she had a problem and instead of permitting her to rush away she was promptly rehypnotized, and was emphatically instructed to recover any and all memories of her trance experiences that would be of use. By stressing in this way the fact that certain of those memories would be valuable and useful to her, the the patient was led to view all of them as possibly useful, thus withdrawing her attention from any conflicting feelings about those memories. This assists in their free and full recovery by the patient. She was told that she should feel free to ask for advice, suggestions and any instruction that she wished, and to do so freely and comfortably. As soon as this instruction had been firmly impressed, the patient was awakened.

Immediately, but with less urgency, she said that she wanted to leave but added that she would first like to ask a few questions. When told that she might do so, the patient asked the hypnotist to state his personal opinion about 'kissing, petting, and necking'. Very cautiously and using her own words, approbation was given of all three, with the reservation that each should be done in a manner which conformed with one's own ideals and that only such amorous behavior could be indulged in as would conform to the essential ideals of the individual personality. The patient received this statement thoughtfully, and then asked for a personal opinion as to whether it was right to feel sexual desires. The cautious reply was given that sexual desire was a normal and essential feeling for every living creature and that its absence from appropriate situations was wrong. To this was added the statement that she would undoubtedly agree that her own mother, were she

living, would have said the same thing. After thinking this over, the patient left hastily.

Therapeutic Outcome

The next day the patient returned to declare that she had spent the previous evening in the company of her suitor. With many blushes she added, 'Kissing is great sport'. Thereupon she made another hurried departure.

A few days later she was seen by appointment and held out her left hand to display an engagement ring. She explained that as a result of her talk with the hypnotist during the last therapeutic session, she had gained an entirely new understanding of many things, and that this new understanding had made it possible for her to accept the emotion of love and to experience sexual desires and feelings, and that she was now entirely grown up and ready for the experiences of womanhood. She seemed unwilling to discuss matters further, except to ask whether she might have another interview with the hypnotist in the near future, explaining that at that time she would like to receive instruction about coitus, since she expected to be married shortly. She added with some slight embarrassment, 'Doctor, that time I wanted to rush away. . . . By not letting me rush away, you saved my virginity. I wanted to go right to him and offer myself to him at once.'

Sometime later she was seen in accordance with her request. A minimum of information was given her and it was found that she had no particular worries or concern about the entire matter and was straightforward and earnest about her desire to be instructed. Shortly afterwards the patient came in to report that she was to be married within a few days and that she looked forward happily to her honeymoon.

About a year later she came in to report that her married life was all she could hope for, and that she was anticipating motherhood with much pleasure. Two years later she was seen again and was found to be happy with her husband and her baby daughter.

Summary and Discussion

For special reasons the treatment of this patient had to be approached with many precautions. The circumstances of her illness made a direct approach to her problem (whether by a man or a woman) dangerous because such an approach invariably caused an acute increase of her panic and of her suicidal depression. She could be treated, if at all, only by creating an elaborate pretense of leaving her problems quite alone, without even letting her realize that any therapy was being attempted, without acknowledging the development of a relationship between the patient and the physician, and without open reference to the experiences which had precipitated her illness.

For these reasons, the treatment was begun by pretending to treat someone else in her presence, and through this means, she was slowly and gradually brought into a hypnotic state in which her own problems could be approached more directly.

From this point on the treatment proceeded along lines which are the reverse of the usual psychoanalytic technique. Some points seem to be worthy of special emphasis.

Instead of depending solely upon memory to recover important experiences out of the past, the patient under hypnosis was translated back to a critical period of her childhood, so that in this state she could relive or revive the general quality of the influences playing upon her, but without recapturing the details of specific scenes and episodes. Instead of stirring them up and making them conscious, there was a deliberate effort to avoid the induction of any feelings of guilt or fear. Similarly, instead of insisting upon total conscious recall, permission was freely granted to the patient to forget painful things, not only during but also after the hypnotic treatment. Underlying this permission to forget was the confidence that even those facts which were consciously forgotten could be recovered during the hypnosis when needed for therapeutic use, and that their therapeutic efficacy would continue even during the posthypnotic repression.

The hypnotist's attack on the patient's rigid superego was

interesting from various points of view. Particularly noteworthy, however, was the fact that the attack on the superego began with a complete support of all of the most repressive attitudes which the patient attributed to her dead mother. It was only by forming a bond in this way between himself and the mother that he was able later slowly to undermine the rigidity of this repressive figure and thus to penetrate the patient's tense and automatic defenses of her mother's dictates. Another significant point is the method used by the hypnotist to help the patient silently to assemble her ideas before communicating them. This seemed to assist materially in reducing the patient's fear of remembering presumably because it is not as difficult to recall embarrassing things which one can keep to one's self, as it is to bring them to mind with the knowledge that one must confess them at once; moreover, once such things have been reviewed in thought, it becomes easier to talk of the thoughts than it would have been to talk of the events themselves. This two-stage method of recalling and assembling data before communicating it might have its usefulness in analysis as well.

A point at which the work of the hypnotist coincides closely with that of the analyst is in the use of repetitions in many forms and at each age level investigated. This use of repetitions is quite similar to what is found to be necessary in analysis as well.

In understanding the course of this treatment and of the patient's recovery, there are many gaps in the material, gaps which could be filled in only by conducting a treatment of this kind in a patient who had been under a fairly prolonged analysis.

There are many questions we would like to have answered. Was the basis of the mother's overwhelming authority primarily affection or hostility and fear? Were the dead mother and the dead friend equivalent? If the hypnotist had said instead that he was the dear friend, and that as the dead friend he encouraged and approved of her love-making with the dead friend's husband (an equivalent of a mother telling her that

she could make love to her father), would this impersonation of the friend by the hypnotist have freed the patient from guilt feelings and from her hysterical depression without the induced regression to childhood? What was the mechanism of the cure? Was the hypnotist equated to her mother, and thus enabled to remove the mother's taboos? Or was the fiancé at first a surrogate father until the hypnotist took over the father's rôle, thus removing it from the man, and thereby making it possible for the patient to have an erotic relation with the man without a barrier of incest taboos? What was the rôle of her orality and its significance in relationship to the vomiting? In general, what was the rôle of all of those basic facts of her early life which must have determined the patient's relationship to her parents and to people in general?

The answers to these gaps in information is challenging, both from a theoretical and from a factual point of view. The knowledge of these facts is indispensable for an understanding of the structure of the illness and the dynamics of the recovery. But the fact that recovery could take place so quickly and without hospitalization, in face of the fact that there were so many things which the hypnotist never discovered and that the patient did not know, also has its important theoretical consequences. It faces us with the question: if recovery can take place with the gain of such rudimentary insight, what then is the relationship between unconscious insight, conscious insight, and the process of recovery from a neurosis?

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THE PREDISPOSITION TO ANXIETY
Part II

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Practical Considerations of Treatment

In a previous paper, The Predisposition to Anxiety,[1] I advanced the tentative hypothesis that severe suffering and frustration occurring in the antenatal and early postnatal months, especially in the period preceding speech development, leave a heightened organic stamp on the make-up of the child. This is so assimilated into his organization as to be almost if not entirely indistinguishable from the inherited constitutional factors which themselves can never be entirely isolated and must rather be assumed from the difficult maze of observations of the genetic background of the given individual. I believe this organic stamp of suffering to consist of a genuine physiological sensitivity, a kind of increased indelibility of reaction to experience which heightens the anxiety potential and gives greater resonance to the anxieties of later life. The increase in early tension results in, or is concomitant with, first an increase in narcissism, and later an insecure and easily slipping sense of reality. I referred especially to the increase in the sense of omnipotence which may occur in a compensatory way to overcome or balance the preanxiety tension state of the organism, and to the increased mirroring tendency arising partly from the primary narcissism and partly from the imperfectly developing sense of reality. This increased mirroring tendency is the antecedent of the tendency towards overfacile identification of neurotic individuals, and in psychotics towards easy projection. I spoke also of the

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derivatives of omnipotence: the overvaluation of the power of the wish and belief in the magic of words. With all of these narcissistic weaknesses, the sense of reality is often very poor and even when it seems quite good, it may be facile rather than strong and break down readily under the fresh impact of anxiety producing situations of later life. Further, owing to the pressure of early tension and anxiety, the ego development is exceedingly faulty; libidinal attachments are urgent but shallow and the ego drives not well directed toward satisfactory goals. The patient is not well individuated and often gives the impression of being in too great a state of flux, with many interests, many attachments, with the libido quickly and urgently invested and withdrawn.

The main general considerations of the treatment of the severe neurotic or borderline states depend upon the characteristics of development described in my first paper. In order to organize my material, I shall discuss these problems of treatment from four main aspects: first, the handling of the overload of anxiety to produce an optimum state for the progress of the analysis; second, the education of the narcissism to better ego proportions; third, the analysis of the 'essential' neurosis; and fourth, the management of the residue of blind, unanalyzable anxiety which is present throughout the analysis and which continues to operate in the life of the patient after analysis. I use the term 'essential' neurosis here to differentiate those neurotic elements arising after the development of speech from the predisposing constitutional ones present before this landmark.

I would for the time being divide the overload of anxiety of the severe neurotic into three subdivisions: first, *the basic,*[2]

[2] I shall use the term 'basic anxiety' throughout the rest of this paper. In the first paper I used the term 'preanxiety' to designate the condition of heightened irritability arising before the dawn of speech and contributing to the later conditions which I am describing in this present paper. I feel justified in using the convenient term 'basic anxiety' as I am now dealing with the adult version of this earlier preanxiety—namely, the form in which it appears as anxiety, or at least amalgamated with anxiety from other sources. The question of the relationship of basic anxiety to the affect of anxiety is one which may well be considered, but cannot be dealt with in this paper.

blind or amorphous anxiety which is always present in some degree and may in moderation furnish some of the drive of life, but which may be so heightened and combined with the anxiety of fresh dangers as to constitute a serious menace; second the *anxiety arising in response to these fresh experiences of danger and frustration;* and third, the *secondary anxiety* arising out of the inadequacy of the neurotic defense and the additional dangers, real or illusory, following the production of the symptoms themselves.[3] What we term secondary anxiety is familiar enough in the form in which it appears in the malignant compulsion neurosis, in which the compulsions or obsessions appearing as defenses against the repressed erotic drives become themselves erotized and require a fresh line of defense to be erected in the form of new obsessional symptoms, until the patient is so involved in the complexity of his fortifications that the rest of life is virtually crowded out. At this stage a secondary atrophy of disuse (habit deterioration; functional dementia) finally occurs, and the end result may be not unlike the schizophrenic process. Although such a malignant development may occur in hysteria also, it is less frequent, less regular in its development and more dependent on the presence of a markedly increased predisposition to anxiety. This is to be expected on the theoretical grounds that the compulsion neurosis arises from trauma and fixation at an earlier level (and therefore closer to the factors producing basic anxiety) than is the case in the hysterical neurosis.

To illustrate the unhappy coöperation of the predisposition to anxiety with the anxiety of later life and finally with secondary anxiety, I shall describe a type of situation which I believe to be nuclear in the development of many severe neuroses.

If the traumata, distress or frustrations of the earliest months

[3] A simple form of this is evident in the crying fit. 'It causes disagreeable visceral sensations, perhaps also pains, and it can end in exhaustion. Even if it does not last that long it can be traumatic for the infant. During the screaming fit the infant is not responsive to any attempts to quiet it.' Benedek, Therese: *Adaptation to Reality in Early Infancy.* This QUARTERLY, VII, 1938, pp. 200–215.

are particularly severe, the stimuli do not remain focussed but overflow through the body and act upon various organs. We see direct evidence of this in the oral, excretory and genital responses at birth and under stress in earliest infancy. These responses may be activated simultaneously rather than in a relatively orderly progression. I shall illustrate the further succession of events by isolating now, for the purposes of description, the genital stimulation and response which arises so precociously as part of a widespread pain-helplessness situation. (I have dealt with some clinical and experimental evidence in my earlier paper.) The response to this situational stimulus is automatic and spontaneous. It subsequently gains an additional pleasure value when the infant discovers the further advantage accruing from body movements which also stimulate the genitals. The genital response next takes on a primitive masturbatory character, more obvious in girl babies than in boys. Although in the latter the appearance of an erection is the visible index of stimulation, the appearance of the most primitive type of masturbation by thigh pressure may be the first evidence of genital stimulation in the girl. The occurrence of repeated and almost continuous stimulation of this sort may produce so prolonged a tonic state as to simulate Little's Disease, and to be capable of interruption only when mechanical obstacles or barriers stop the masturbatory activity.[4] At any rate, where a polymorphous discharge of tension has been carried on in the organism at a very early date, we may conceive of its leaving a heightened irritability for channels of discharge in later life, intensifying first the reaction to traumata of later infancy and early childhood which form the understructure of the essential neurosis, and then, at later periods in life heightening the anxiety of frustration and danger and aiding in turning the flow of activity backward along the old channels rather than continuously forward. If the anxiety is

[4] I first became aware of the reappearance in a changed form of this initial genital stimulation in anxious states of later life through a series of clinical observations made during my preanalytic work. I have put these together later in the paper in the section dealing with clinical case reports.

severe at these later periods in life (and it is likely to be severe because of the established predisposition) the overflow response of the earliest days or weeks of life may be repeated, and anxious erotic stimulation again occur. This is the setting of the frantic compulsive masturbation which so often precedes a psychosis. At these later periods in life, however, such masturbatory response is no longer the simple psychological response of the days after birth, but has accumulated the special wrappings of sado-masochistic fantasies (partly or wholly unconscious), guilt reactions, etc., which have invested its development in the intermediate stages. Thus the vicious whirl is set in motion.[5] The poorly developed sense of reality begins to go to pieces, bringing a threat of collapse to the ego; panic and sometimes dissociation ensue. This secondary anxiety may be further increased by inept and poorly directed treatment of the patient, and follows regularly in types of treatment which consistently undermine the patient's confidence in himself and limit his spontaneous activity, as in poorly advised and arranged hospitalization.

While I have singled out for description the course of the early genital response from physiological tension stimulus and response to masturbation, and have indicated its vicissitudes in later development, it is clear that a somewhat similar course may occur in the case of the nongenital areas (oral, anal, cutaneous) and that the selection of the one or of the other for first place is largely determined by the special traumata of later infancy (the roots of the essential neurosis).

Patients suffering from severe neuroses quite often come to analysis in a very acute state of anxiety or even panic. Subsequent panic states, however, seldom surpass those which brought the patients into treatment or those which were precipitated at the outset of treatment. If the experienced therapist watches the anxiety of his patient carefully and tempers the treatment accordingly, such panics will occur in

[5] Rado described the ego aspects of such a struggle in a vicious circle in *Developments in the Psychoanalytic Conception and Treatment of the Neuroses.* This QUARTERLY, VIII, 1939, p. 27.

the course of treatment only if some new danger appears. Even then the panic can generally be avoided. Obviously a patient who is frenzied or in a panic is in no state to be analyzed. He is much too near to a state of psychic paralysis to lend himself to the analytic process. The first aim of treatment must then be to penetrate the panic and relieve some of the anxiety. In this the composed, firm, assured attitude of the analyst is of the greatest importance.[6] As is to be expected in such highly narcissistic patients, the tendency to exhibitionism is great and is unconsciously used by the patient, in reaction to the intense underlying fear, to excite the sympathy and counteranxiety of the analyst in a desperate effort to retain neurotic control of the situation. Such patients simulate the behavior of psychotic patients and the inexperienced analyst may indeed be alarmed by them. It is extremely important in these early stages to have the understanding coöperation of the people who are close to the patient during most of the other twenty-three hours of the day, whether this be in a hospital or at home; much of the gain of the therapeutic hour may be lost by hostile, solicitous, or too active friends or relatives. Naturally this means that the analyst has to be in contact, directly or indirectly, with some key person in the patient's milieu, and this may create problems later in the analysis. In my experience, this initial situation has been handled most readily when some other analyst has been in contact with the family of the patient as friend, relative, or professional interpreter.

A word about the rôle of reassurance: most patients seem to react badly to direct reassurance. A quiet attitude of knowing one's business usually suffices; on occasion one may remind the patient very simply that we are the doctor and he the patient. Such patients have often been treated previously with too much reassurance. They beg for and distrust it because they have

[6] This need of the psychotic patient to be met with calm receptivity is emphasized by Dr. Dexter Bullard in his account of the organization of psychoanalytic procedure in the hospital. J. Nerv. & Ment. Dis., XCI, No. 6, 1940.

in the past been overly placated, comforted and lulled with promises that could only come to naught. The same thing is true of advice. Although emergencies occur with appalling frequency at this stage, the analyst is in a better position if he does not permit himself to be drawn into the rôle of adviser. The patient is quick to seize upon any weakness, inconsistency, or falseness in the analyst's attitude, and if inadequate advice or superficial reassurance is given, it undermines rather than strengthens the patient's confidence. Calmness in the analyst induces calmness in the patient, and it is not generally necessary to be more 'active' with these patients at this stage than later, although it is very easy to be drawn into active participation. Because of the patient's insecure hold on reality, the analyst must maintain an attitude of clear, hard, unperturbed realism, and must refrain from giving verbal assurance.[7] Patients respond well to a simple clear statement defining rather than sympathizing with their disturbed state. It gives them relief and a feeling of security to know that the analyst sees through their surface situation and sees it as bad as it is, though not in the exaggerated terms in which they have presented it. A negative therapeutic attitude is encouraged if the analyst is too gently sympathetic, shows solicitude or anxiety. Obviously this increases the secondary gain of the neurosis and draws it further into the analytic situation.

Some patients will force an emergency or a crisis with a

[7] Years ago Dr. Brill emphasized the necessity for the therapist to reiterate, consistently and firmly, a realistic negation of the schizophrenic's distortions. This was done patiently and without argument. But Brill was dealing with a group of patients who were more frankly psychotic than those I am reporting, and his therapy, although based on analytic insight and judgment, could not be considered psychoanalytic. (Brill, A. A.: *Schizophrenia and Psychotherapy*. Am. J. of Psychiat., IX, 1929, p. 519.)

Dr. Zilboorg, reporting the treatment of a paranoid schizophrenic patient, also emphasized the preliminary state of reality testing before the analysis itself. His patient had been in a definite psychosis, and the subsequent recapitulation of the psychosis in an acting-out in the analytic situation was at once more dramatic, and more massive than is the situation in the severely neurotic patients of my own study. (Zilboorg, Gregory: *Affective Reintegration in Schizophrenia*. Arch. Neurol. & Psychiat., XXIV, 1930, p. 234.)

demand for a decision or for advice; and to ignore this is to push the patient to an even higher pitch of frenzy and perhaps to some disastrously convincing exhibitionistic act. Where I think this may occur, I indicate a course of action to the patient, usually with a succinct restatement of the possibilities which he has already indicated to me. It is possible to put a little more emphasis in one direction or another while being very careful to leave the impression of autonomy with the patient (e.g., 'You may find you wish this, or that; but the decision will naturally be your own'.) In this way the appearance of stubbornness or evasiveness on the part of the analyst is avoided, the patient gains in self-reliance, and the first step in the education of his narcissism is begun.

There is one other tendency which appears throughout in such severely ill patients and which must be 'managed' as well as analyzed. This is the habit which Stern [8] once graphically and tersely characterized as 'scab-picking'. I had myself already made use of the analogy of 'pulse feeling'. This can be so severe as almost to crowd out other mental activities, and it must then be dealt with before the initial stage can be passed and the deeper work of analysis begun. It is usually adequate to call the patient's attention to this process insistently and to interrupt it repeatedly. This tendency is so clearly a kind of masochistic autoerotic gratification, analogous to compulsive masturbation and to some forms of brooding, that it must be repeatedly interrupted in order to turn the energy elsewhere even temporarily. The 'scab-picking' is itself partly a derivative of the active but poor coöperation of the strong superego and the weak ego; it frequently utilizes a highly developed scoptophilia turned back on itself. Late in the analysis, when the narcissism has been sufficiently educated to result in a strengthening of the ego, what remains of this self-watching

[8] Stern, Adolph: *Borderline Group of Neuroses.* This QUARTERLY, VII, 1938, p. 467. Dr. Stern's article touches on my own observations in many respects, and mentions also the 'deep organic insecurity or anxiety', with which my study is largely concerned.

tendency may be converted into a genuine capacity for self-criticism, indispensable for the management of the residual basic anxiety.

In general, then, the work of this part of the analysis is to increase the immediate reality hold of the patient, first through the attitude of the analyst, then through the relentless defining or clarifying of the immediate conscious attitudes and problems of the patient, and finally through the interruption of special self-perpetuating autoerotic tension states. While this must be done at the beginning of the analytic work, it is rarely accomplished adequately in the first stages of the treatment and usually has to be repeated in many different ways through the course of the treatment.

This stage of treatment differs from the beginning of any analysis only in its greater importance, not only early but often throughout almost the entire course of the analysis. Because of the patient's insecure sense of reality, the larger topographical outlines of the reality problems and the reflection of the unconscious factors on reality situations have sometimes to be gone over and over with almost monotonous repetitiousness. In this way there is an infiltration of this sort of insight into the microscopy of analytic work and there ensues a helpful organization of the latter in a manner which places it at the disposal of the patient. One must guard against making the analysis simply a tour of minute morphological inspection.

Analyses of these severe neurotic states are inevitably long. The sooner the patients and their relatives accept this and settle down to the analytic work, the better. The patient himself is usually under considerable urgency and scab-picks at the time element as well as at other aspects of the total situation, keeping himself in a state of pleasurable disappointment, attempting to extract promises and time-tables from the analyst. To such patients and their relatives I emphasize that analytic work involves genuine growth which can not always be budgeted or scheduled.

Throughout the analysis there exists the need for a strengthening of the patient's ego through the education of his narcis-

sism. As a part of this, a reduction of the tendency to easy and widespread identification should be accomplished.[9] This occurs partly spontaneously through the liberation accomplished by the analysis of the essential neurosis, but it has to be reënforced through a training in its actual recognition as a general tendency, and a self-critique must be established in regard to the tendency. By these means some of the otherwise dissipated energy may be reclaimed and brought back into the service of the ego. Many of these patients have a remarkable poverty of interests, i.e., very few external goals of ego achievement; or if they have any, they have too many and flit from one 'interest' to another, developing nothing satisfactorily. In the first instance, the analyst has to help the patient to find some satisfactory goal, and in the second, to select or organize those which he has already found. This can not be done by prescription, suggestion, or even by direct encouragement, for the patient reacting assertively to any positive direction (and rightly so since such direction would only increase the dependence with which he struggles), then lays the responsibility on the analyst and blames him for uncertainty or failure. Patients often demand such advice and would almost trap the analyst into giving it only to disregard or disprove it, and so prove their neurotic negative 'strength'. It is possible sometimes to accomplish the desired result by an adroit underlining of the patient's own inclinations, again emphasizing the patient's autonomy. 'You will find interests ready for you as you are ready to invest in them. It is unnecessary to force yourself (in one direction or the other), but only to take steps as you yourself feel at all ready for them. Even then you may be disappointed.' It is like helping a child with the first steps of walking.[10]

[9] Schilder describes this florid tendency to multiple identification in the schizophrenic in his chapter on Identification in Schizophrenia in his *Introduction to Psychoanalytic Psychiatry*. New York: Nervous & Mental Disease Monograph Series No. 50, 1928.

[10] I combat the tendency to a negative therapeutic reaction here by being slightly negative myself: never praising, rarely permitting myself any enthusiasm, but definitely recognizing ability or achievement when it is shown, and

The analysis of the essential neurosis of such a patient is not fundamentally different from the analysis of any neurosis. The first stages of the analysis may have to be prolonged in order to strengthen the patient to bear the distress of the later analytic work. This has often been spoken of as the period of preparing a patient for analysis. In my experience, this work can hardly be confined to a preparatory time but has to be continuously reënforced throughout the analysis by constantly working through the material with reference to the current situation and the infantile roots of the behavior and symptom patterns, never omitting the larger outlines of behavior tendencies as a framework for the dissection of the finer details.

In the analysis of these severe neuroses, the risks involved in giving too early interpretations for which the patient is not ready are greater than ordinary. The temptation to do this may be great as the patients so often present rather florid material and have themselves some inkling of the symbolization involved, in this respect resembling the frankly schizophrenic individual. Patients meet premature interpretation by a marked increase in their defensive walling off or they seize upon the interpretations to construct an intellectualized formula which serves their narcissistic demand for magic and with which they may satisfy themselves temporarily and dazzle their intimates sufficiently to give the semblance of a cure. They improve temporarily because they have been given a magic initiation. This can be avoided by giving interpretations with special caution and always working back from the current situation to the deeper roots, never allowing the analysis to become strangulated at one level or the other. Great analytic

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always indicating to the patient that he may achieve further. I believe this attitude is more in keeping with the need of the patient for reality above all else; at the same time it diminishes overstimulation with subsequent disappointment, and avoids the pitfall of having the patient do things to please me. Others may find it possible to establish activity first on the basis of pleasing the analyst, and subsequently analyze this oversubmissiveness after the patient's activity has gained a certain momentum of its own. I presume these differences of procedure must depend in some measure on differences in the temperaments of the analysts.

agility is sometimes required in order on the one hand not to allow the ever-ready deluge of anxiety to overwhelm the patient, and on the other hand not to permit the patient to rest on the relative comfort of somewhat reduced anxiety. To keep him at his analytic work, he should have enough anxiety to spur his effort, but not so much as to block it.

It is equally important, however, not to *overlook* the essential neurosis. The symptoms are often embedded in wider tendencies of behavior, and the improvement from the concurrent education of the patient may be so striking that it may be easy to be fooled into dealing inadequately with the neurosis itself.

There are some peculiarities of the transference relationship to be considered. The transference at the beginning of the analysis is generally urgent but shallow, and characterized often by an ambivalent identification with the analyst. These patients ask everything and trust nothing.[11] Later in the analysis it may develop into an intense obligatory erotic transference. Throughout it is a relationship of exquisite sensitivity.

These patients have in the very nature of their organic sensitivity to experience a remarkable faculty of observation, but not so good an ability to make use of it. The constant mirroring of life and the diffuse competitiveness resulting from this is evident throughout, especially in the dream material. The patients seem to hear and see everything about the analyst, his situation, his family, etc. They take in and register a mass of details without being aware of them. These reappear only slightly disguised in dreams which are full and remarkably elaborated. At the same time the patients are less able than are those suffering from milder neuroses to use the transference readily as a genuine medium of working out the reflected intricate patterns of their behavior, and only seem to achieve this in the ordinary way towards the end of the analysis. While the mirroring tendency produces the sem-

[11] *Cf.* Fromm-Reichmann, Frieda: *Transference Problems in Schizophrenics.* This QUARTERLY, VIII, 1939, p. 412.

blance of the transference in most of the patient's dreams, the continued detailed analysis of its appearance tends either to confuse or merely to fascinate the patient. Consequently in the transference relationship too, one has to work early especially on the general larger patterns. Only after the patient's tendency towards identification has been somewhat reduced is it possible to do much detailed transference work with him.[12]

Because of the remarkable capacity for observation on the part of the patient, any changes at all in the analyst's arrangements are reproduced in the patient's dreams and attitudes. Sometimes these may by good chance bring out some special pocket of material from the patient. More often, however, they serve as artifacts and unnecessary complications in the analytic picture. For this group of patients it makes for a real economy of work to keep the immediate environment of the analytic work as constant as possible.

Later in the analysis the development of an erotic attachment to the analyst can readily cause the accumulation of transference anxiety. This is particularly intense in the patients under discussion, as there may be in them a considerable deepening of emotional experience and libidinal expansion occurring in the course of the analysis and not for the most part after it is over. In this sense the transference represents more than a 'transference',[13] since there is an addition of new elements not previously experienced by the patient. Such a transference presents one of the greatest values and some of the severest problems of the analysis, as the dissolution of the transference demands the realignment of the deepest attachment the patient has yet felt. How much erotic tension piles up in the trans-

[12] In years past, in my psychiatric experience, I have seen patients quite often thrown into brief psychotic episodes by too assiduous and early work with the transference. I believe this still happens though not to the same degree, since the emphasis on continuous detailed interpretation is less. These episodes were not followed by any prolonged psychotic states. We used to refer to them as 'psychoanalytic deliria'.

[13] This was exemplified in an even more intense form in the affect hunger described by Dr. David Levy in *Primary Affect Hunger*. Am. J. Psychiat., XCIV, No. 3, 1937.

ference and how readily it is deflected onto and used in the reality of the patient's life clearly depends first on the specific life situation of the patient when he enters the analysis, and second, on how the analyst handles this emotional current. In these severe neurotics constant drainage of this is necessary, erotic tension never being allowed to accumulate and stagnate. One should deal with it by always indicating directly or by implication the other love goals to which the current must return. The erotic tension thus escapes becoming fixed in a transference bondage or coming to an explosive rupturing.

The patient must become acquainted during the course of the analysis with the necessity of managing his own basic anxiety, which is not completely analyzable and will always remain at least potentially with him. Neglect of this part of the treatment may cause the subsequent breakdown of much of the accomplishment of an otherwise effective piece of analytic work. The patient must acquire a considerable degree of self-critique and self-tolerance. In the course of the analysis, I gradually acquaint the patient with the fact that analysis will not be a complete revelation or a magic rebirth such as he demands; that he will in fact always have problems of tension and balance to deal with. This tempering of his expectations may be started very early in the treatment, with the same firm realistic attitude which is generally effective in combating his panic. If this is coupled with a clear statement of the fact that there are definite gains to be legitimately expected, it stimulates the patient to work rather than discourages him. Then as the work proceeds, he is gradually made familiar in a very simple way with the theory of basic anxiety. This is not given him as a packaged theory, but is interpreted to him as he refers to the material which, according to my mind, justifies such a theory. These patients always give some accounts of what they have heard regarding their own births, possible antenatal influences, and earliest postnatal experiences. These come to the surface often directly, sometimes combined with birth theories and fantasies of later childhood which again are revived in connection with current

contacts with birth experiences. As patients speak of their own birth injuries, their earliest illnesses, accidents, the attitudes of their mothers towards and during pregnancy, I reconstruct for them the possible effects of such experiences on a young child, and indicate the inevitable contribution to the general tension and amorphous anxiety of the later adult. In this connection, it is interesting that one can in the course of such interpretation pretty well reconstruct what has been the specific experience of the given patient. He does not recover clear memories or confirmatory evidence which he can convert into words, but he reacts with wincing, increase of tension, or the appearance of confirmatory somatic symptoms when the old sensitive areas are touched, even when this has to do with events of the very earliest weeks and months of life.[14] It might be expected that this sort of interpretation would furnish the stuff for a negative therapeutic reaction and that the patient might fall back on the attitude, 'I was born that way; so what?' This has not been my experience. Perhaps it is counteracted by the special attention already paid to the education of the narcissism. These patients must learn to know and appreciate themselves as genuinely sensitive individuals, and come to utilize their sensitivity if possible. In this way may be built up a valuable self-critique which is then at the disposal of the patient rather than turned against him. Finally at the end of such an analysis there has generally occurred a reorganization of the individual. The level of the tension may still be somewhat elevated. But if the essential neurosis has been adequately dealt with, the organization is sounder, the behavior more spontaneous, and the balance less easily tipped. Such treatment is, perhaps more than an analysis, an education; in procedure it necessarily lies somewhere between the classical psychoanalytic technique and the methods used with children.

[14] One sees here very clearly the significance of Freud's statement that the symptoms take part in the discussion. In this part of the analytic work, symptoms are the patient's main discussion.

Clinical Studies

In presenting the clinical material in connection with this paper and the previous one, I give only one case history with any degree of fullness but shall first present briefly from a clinical experience extending throughout a number of years, the observations which formed the beginning of my queries about the effect of birth and other early traumata on the production of a tendency to anxiety.

A. One of my patients, a competent and serious unmarried lady in her late thirties, suffered from hysterical symptoms. On the periphery of these was one which did not yield readily to analysis. This consisted in certain irregular jerky movements with her feet. She complained that when she was driving her car, the free foot tapped rhythmically on the floor of the car. This was not a tic, nor yet a genuine compulsion, but an inconstant and semivoluntary act which she found herself repeating like a bad habit. She also noticed that when in company she was tense and felt people were looking at her, she was unable at times to keep from wriggling the toes sometimes of one foot and sometimes of the other. This embarrassed her, although it seemed to her that she did it only under scrutiny and to relieve embarrassment. It was obviously an autoerotic discharge in a state of mild anxiety, but like other neurotic symptoms, it turned back on its purpose and increased the state it seemed intended to relieve. The same patient gave a history of having rubbed her toes on the sheet in order to put herself to sleep in her childhood, a habit which was maintained until she was six or seven and which recurred subsequently especially during illnesses until puberty.

In the analysis of this patient's dreams, there were a number of associations which indicated the familiar foot-penis symbolism. This patient suffered from an unrecognized extreme envy of her brothers, among whom she was the only girl. I shall not attempt to go into the whole story of the neurosis, but I was puzzled by the route of selection of the foot in this particular case. I thought at first it was a simple displacement downwards, occurring with partial or complete renunciation of infantile masturbation. It was evident that the foot and leg were equated with the penis (and also breast) not only in accordance with the familiar sym-

bolism but also directly by association with her mother who had suffered a milk leg earlier, and then later became lame from other causes when the patient was at puberty. One could readily see that the foot tapping was a combination of the illusory penis masturbation and an anxious exhibitionistic calling attention to her castrated plight. But the patient's original foot rubbing to put herself to sleep was said to have occurred from 'earliest infancy'. Her mother had told her that she had been a quiet baby and had slept well, except for the foot rubbing and some thumb sucking. It seems clear that the foot erotism had preceded the problem of castration anxiety and penis envy and had certainly antedated the mother's lameness and knowledge of the milk leg story.

B. In seeking the possible derivation of this patient's symptoms I recalled another patient who some years ago had told me that at the height of an orgasm she would have peculiar tingling sensations in the toes of both feet. There were certain similarities in the developmental histories of the two patients. Neither remembered childhood masturbation but had come upon masturbation in adult years when it occurred 'spontaneously' as part of a diffusely felt sexual arousal with sensations emanating from the genital areas and spreading throughout the body. In the patient under discussion this had occurred in the setting of a quasi intellectual erotic stimulation (reading and looking), and seemed to her a short-circuited response. In both patients the masturbatory habit was a recurrence of the most primitive thigh-pressure type. In neither case was there any clitoris masturbation. In the second patient, the masturbation was accompanied by fantasies of intercourse which, in the patient's imagination, consisted simply of holding the penis within her vagina, i.e., clearly a possession of the penis in this way. It seems probable that the masturbation which had been initiated so late was only a recrudescence of what had occurred and had been renounced very early in life.

This type of genital sensation without awareness of any preliminary stirring or fantasying but consisting rather of sensations suffusing suddenly upwards from the genital region and extending throughout the body, reminds one of the distribution of dissociated and disclaimed erotic sensations described

by schizophrenic patients as due to electrical or hypnotic influences.

There is one other fragment of a case history, which I recall from my early clinical experience, of a young woman who was at first considered to be a very severe case of hysteria. This young woman had an autoerotic orgastic tic with a sucking muscular movement culminating in a snapping noise sufficiently loud to startle bystanders. I have recently been able to learn the bare details of the later history.

C. This young woman first came to the hospital at twenty-three because of especially violent quarrels with her father in which she threatened to kill him and also threatened suicide. The family was one in which talent and instability intermingled and fused. The father was a brilliantly able man, who sank later into a cranky senile state. I saw this patient first twenty-one years ago. She was the third among five children. One had died of meningitis, and one had had a manic attack precipitated by the torpedoing of his transport during the first World War. In the years since, a younger sibling too developed a psychosis, so that four of the five children developed severe psychic disturbances. Genetically determined constitution may be considered to have had a possible influence here; however, the early individual history is also of note. The patient was a seven month baby, cyanosed and weighing four pounds at birth. Because of a neglected ophthalmia neonatorum, her vision was permanently impaired and a constant lateral nystagmus developed. There were many fainting attacks in childhood. She was never able to study adequately, both because of the reduced vision and because of inability to concentrate. She had a particularly severe temper with sudden exceedingly violent outbreaks occasioning chagrin and a religio-moral struggle for control. She became a religious fanatic and wished to be a Deaconess. Masturbation occurred throughout the entire childhood, and she could recall no period in which it was even temporarily in abeyance. The childhood history was so full of sexual traumata, explorations and experiments with other children and with a variety of animals, as to give the impression that this frustrated child was in a state of continual autoerotic overflow in which her impulsive discharges set up new excitations until she was involved in a frenzy of polymorphous perverse excite-

ment with almost no relief. In this patient, too, masturbation by thigh pressure was the earliest and still predominant form of masturbation, although to it had been added a great variety of autoerotic practices.

In the hospital she was at first extremely scattered, distractible and restless; she then developed the tic, which was clearly an effort at relief. 'If it does not occur my eyes get misty and roll up into my head, and my brain gets confused.' She described it as 'a contraction and expansion of one of my organs'. It occurred, however, without her volition and became a thoroughly automatized tic. She complained also of pain and a feeling of paralysis in both legs and sensations in them 'like mercury in a thermometer'. Withal she moved about freely.[15]

Obviously this case presents a mesh of complications. But I quote it here because of certain similarities in symptom constellations with other cases. Having recently obtained an abstract of the history of the younger sister of this patient who suffered a psychosis some seventeen years later, I have learned that all of the children in the family were born by extremely difficult labors. It thus appears that this part of the family situation, dependent on the pelvis of the mother, and an accident as far as the children were concerned, may have combined with and reënforced the later results of the pathetic neglect which the patient suffered as a child.

In thinking over the possible relations of this pressure masturbation to the toe, foot and leg symptoms in these cases, I believe that I may have come upon a somatic rather than a purely symbolic link in the possibility that in severe pressure masturbation of this type, where the body is held in a state of prolonged, frenzied, autoerotic tension and the legs crossed in scissor fashion, there may actually be referred sensations of tingling in the legs and feet. This seemed to me the more probable when I recalled having seen several times in my student days on a pediatric ward, cases of very young female infants in exactly such states of unrelieved tension, with the body in a condition of rigid tonicity and legs crossed scissors-

[15] I wish to thank Dr. Adolf Meyer for permission to use these and other clinical observations from the period of my work at the Phipps Clinic.

wise. I recall that one of these little patients was at first thought to be suffering from Little's Disease because of the history of birth trauma and the superficial resemblance of the posture to spastic paraplegia. Separation of the infant's legs with soft cotton pads was followed by the cessation of this masturbatory tension and a relative degree of general relaxation. The recollection of these instances of very early masturbation in girl babies then related itself to the observations of erections following delivery of boy babies, and the line of query which I have developed in my first paper began to take form.[16]

Any one who has attempted to give a fairly full account of the analysis of a single case, knows how difficult this is. The mosaic of the analysis is inevitably complicated and delicate and while a few relatively simple patterns stand out boldly in almost all cases, what pattern unit stands out most sharply depends on the angle from which the whole is viewed. Thus, what looks like a diamond to one person may look like a cross to another. It is often important to establish *some* pattern unit, at any rate, and go along from there. In dealing with the following case history, I have found it impossible to present all my data and have consequently organized it for purposes of presentation along the lines already indicated. It was the tendency of this material to organize itself along these very lines, however, which stimulated my attempts to bring together my observations and to formulate ideas about treatment of this group of severe neuroses.

D. This patient came to me at the age of twenty-eight, a trim young woman of small stature, probably not more than five feet or five feet one inch tall. Her figure inclined to boyishness, especially in the straight slimness of the hips, but this was by no means conspicuous. The upper part of the torso was feminine and the breasts well developed, but with inverted nipples. There was a slight excess of hair on the forearms and a little heaviness of the hair of the upper lip. She walked in an overly energetic tense fashion, with her head thrust forward, her arms swinging

[16] *Cf.* Lorand, Sandor: *Contribution to the Problem of Vaginal Orgasm.* Int. J. Psa., XX, 1939, p. 438.

freely. Her speech resembled her gait in being hurried, urgent, inaccurate, and often ahead of itself. She was accompanied by a nurse companion, as she was afraid to go any place alone.

At the time I first saw the patient I had already been given the general facts of the formal history, and all arrangements had been made in advance for her treatment. Another analyst was in touch with the family and had done the not inconsiderable job of explanation and interpretation of treatment to them. The patient came with the anticipation of being analyzed, but she accepted analysis as a last and probably futile resort and was not kindly disposed to it.

The presenting symptoms were those of a severe anxiety hysteria, with phobias, a tendency to doubt and some compulsive activity. She was afraid to be alone, afraid of high places, and especially of windows above a ground level. In attacks of panic she was afraid of losing consciousness. At other times she described herself as dazed and without positive feelings, 'as though I were looking inward instead of outward', and again, as though she 'just stared out'. Sometimes she felt as though she were not herself, and her face felt stiff. She felt like an infant and was afraid of drowning in her tub. Again, she felt very tiny, like 'just a tiny atom lost in space'. Sometimes she insisted she was feebleminded. Going to high places, having to eat alone, going to the hairdresser, or being in any situation in which she sat directly facing another person, were all situations in which she was likely to have anxious feelings mounting almost to panic. At this particular time she could not bear to look in a mirror, which was as bad as having any one else look at her. She was tense almost to the point of frenzy, but there nevertheless appeared an element of play acting in her manner.

She had really been sick most of her life, and while one could recognize stages of change in her symptoms, there had been only a few relatively short periods when she had seemed reasonably well and active. She had never finished school or held any position. (Tests, however, had indicated her to be well above average intelligence.) She was married and had a daughter of four, and kept up an intermittently active participation in the social affairs of her friends. She had been more or less in contact with psychiatrists and psychoanalysts since the age of seventeen. At that time her parents consulted an analyst who advised that they take her

to Vienna to Freud. A neurologist thought a Eurpoean pleasure trip would be better. Later she was successively in the hands of a psychiatrist, a child guidance specialist, and what appears to have been an 'analyst' without training. She spent two years with this man and became quite familiar with the general symbols and some of the concepts of analysis. Next an analyst advised against analysis and the patient then entered a psychiatric hospital. There she remained for about seven months, showing marked improvement at first and then getting rapidly worse, with the appearance of more marked frenzy and desperation than at any time previously. She was now so bad that it seemed impossible for her to live outside of a hospital and in order to start the analysis it was arranged that she remain hospitalized but commute daily accompanied by a companion. All arrangements were made with the help of another analyst who was a friend of the family and proved an invaluable aid during the first months of the treatment, acting as an interpreter and shock absorber in the situation.

I shall not attempt to describe the minutiæ of the therapy. It proceeded essentially along the lines I have already described. At first the patient behaved in a crazily frenzied fashion reminiscent of the 'antics' of patients in a psychiatric hospital. She would refuse to lie on the couch though she knew from her previous experiences that this was expected. Sometimes she paced about threatening to throw herself on the floor, or walked up and down wringing her hands. She went through the motions of choking herself and threatened to jump in front of a train on the way to the office or to jump from a window. She would sometimes ask me how I dared to let her go around outside of the hospital. She attempted to entice me into some commitment about the outcome of the analysis, the length of time, my expectations, etc., and she tried a number of bullying methods. She told dreams and quickly gave crude symbolic interpretations, sometimes saying, 'I suppose *you* would think that means thus and so'. She now repeated in order to discard them the many symbols learned in her previous 'analytic' experience. She was mildly obsessed with a great variety of sexual thoughts—a kind of pansexualization of thought content which may have been partly induced by the previous rather blunt therapeutic efforts. It was usually futile for me to say more than a sentence or two, as she would turn her head away and say 'I am not listening to you. I don't hear any-

thing you say'; or 'I can't hear you, because I can't concentrate'. A little later she was able to hear more of what I said, but often attempted to convert the session into an argument, amply demonstrating the basis for her having been affectionately dubbed 'a last word artist' by her parents when she was a child. When she asked me if I were a good enough analyst to treat her, she was surprised when I simply said 'Yes'. (This served to check temporarily the potential sado-masochistic argument with which the patient was used to drowning out all therapeutic contacts. Somewhat later I was able to help her first to see that she blocked her own progress in this way, and later to begin to analyze these tendencies in herself.) She was an inveterate scab-picker, sometimes drawing her husband and her mother into the process by scaring them with her behavior and inducing them to call me up, then demanding verbatim accounts of what our talk had been.

During the first two or three months there was a gradual simmering down. Her failure to arouse counteranxiety in me was probably the most effectively 'reassuring' factor. Gradually I began the most elementary explanations. Ignoring the symbols which she displayed so generously, I began with simple suggestions that her feeling like a little atom was a kind of picture of her feeling lost in the world, that she didn't really feel grown up and able to take care of herself, and that being unable to be alone was like being a child again. Even this was too much for her at first, and when she once grasped the idea that she was reacting to a feeling of insecurity in many ways, she was relieved that at last she had understood something. This is just an indication of the extreme simplicity with which we began. The gradual deepening of her understanding, the emphasis on her appreciating herself as an individual, her increasing ability to assimilate more and more interpretation and the extreme caution with which progress could be made, can be imagined from the content of the patient's history. These first weeks were essentially a stripping off of the secondary adornments of pseudo-psychotic behavior which she had picked up in a psychiatric hospital, together with much of their complement of secondary anxiety. She began to feel that she had rights and independent functioning. The use of the simplest sort of explanations permitted her to abandon the analytic vocabulary which she had previously acquired and which served

only as a meaningless burden to her, having already lost even the quality of being magic words.

This girl was the first child and second pregnancy of a young mother. An earlier tubal pregnancy resulted in operative interference and a stillborn fœtus. The maternal grandmother died suddenly ten minutes after the patient's birth. The mother then went to her father's home to live and to take her mother's place with the grandfather. The family remained there until a second child was born twenty-seven months later. (This story was part of the family saga and the patient could not remember when she first heard it.) The patient was delivered by cæsarian section because of the mother's contracted pelvis. She was a fretful baby in spite of the fact that she sucked her fingers from earliest infancy, presumably beginning the first week of life. At a very early age she began sucking her blanket. She recalls that later she sucked the blanket and then smelled it before falling asleep. In summer she had to have a piece of flannel to suck and smell. Intermittent finger sucking occurred until the patient was fourteen or fifteen. It then was gradually replaced by smoking which is still a deeply fixed habit and is largely an oral pleasure; she inhales little and is as well satisfied with an unlit cigarette in her mouth. Another childhood habit was rubbing her foot on the blanket in order to put herself to sleep. In adolescence she twisted her hair with her fingers continually. She was nursed until she was a year old and was then weaned on principle rather than exigency. She wet the bed throughout her entire childhood up to the age of seventeen, when there was a further extension of neurotic symptoms. She was constipated intermittently in childhood and was given enemas frequently. One of her early recollections was of being held struggling and fighting on the bathroom floor while the mother inserted the enema nozzle. She masturbated throughout childhood. This was a rather ineffective clitoris masturbation described by the patient as 'touching myself but not working at it'. The details of the beginning of her speech are not known to the patient, but she recalls having had a mild speech defect, something of a lisp, which gradually disappeared at eight or nine. Later in life she complained a good deal about getting mixed up in her speech: under any excitement she used words which had the approximate sound of those she wanted—a mild degree of

malapropism under stress. There were no serious illnesses except mastoiditis in the patient's infancy. She had had occasional spurts of fever, however, often accompanied by brief delirium, and on one occasion a series of convulsions.

When she was twenty-seven months old, a younger sister was born. The mother was permitted to go into labor, which proceeded unsuccessfully for some time; then forceps were applied and the child was severely injured. From the first it was feared that the baby would not develop normally, and by the time the baby was two or three years old it was evident that she was both deaf and an imbecile. At the time of the birth the mother had gone to another city for delivery, taking the older child with her. On the train returning home, my patient, then twenty-seven months old, developed acute mastoiditis necessitating a mastoidectomy. She remained in the hospital nine weeks and later had to have very frequent dressings. She fought so against these that an anæsthetic was given, and she is supposed to have had chloroform almost daily for some time. (This is the mother's account. The patient herself has always thought it would be impossible to have been anæsthetized as often as the mother reports to have been the fact.) The patient's earliest conscious recollection is of being held by her nurse, looking out of a window in the hospital and watching some negroes on a nearby roof. The mother devoted herself to caring for the patient but was under great stress in her position as successor to her own mother and in concern over the next pregnancy. (A certain œdipal ambidexterity was patently needed.) After the sister's birth, first the patient and then both the children were in charge of a *Fräulein* who was very strict and methodical and punished them severely for spilling anything. The two children were brought up together until the sister was about six, when the latter was sent away to a special school.

The patient's neurosis developed in successive stages and with increasing intensity (1) at seventeen, when she first went away from home, (2) during her engagement and (3) after the birth of her child. It just happened that the birth of this child came in a period when there were many deaths in the family, so that again birth and death were juxtaposed even as they had been at the time of her own birth when her grandmother died ten minutes after she was born. At the time the patient entered analysis, she stated that her sexual response was good, i.e., that

she usually had an orgasm in intercourse. It developed, however, that she was averse to intercourse and had an inadequate orgasm overly readily.

In considering the etiological factors in this young woman's illness, I shall confine myself to the simplest statements in regard to the two groups: the very early, *predisposing* ones, and those producing the *essential* neurosis. In regard to their effects, it is not possible to make a clear cut distinction between those predisposing causes resulting from the genetically determined constitution and those arising predominantly from the very early distresses which I have conceived of as leaving an organic (constitutionally assimilated) imprint in their wake. I believe that these two groups of factors are inevitably together and sometimes fused.

In this case, we have a history of competence and some brilliance on both sides of the family, but with an incidence of neurosis which seems very high. In addition the mother was tense and apprehensive during her pregnancy with the patient, as her previous pregnancy had ended in a defeat and suffering for her. She was, incidentally, a rather undaunted sporting type of woman, with considerable bravado as a cover for her disturbance. Although there were no particular data regarding the patient's nutritional state at birth, my surmise from the contents of her symptoms and dreams would be that she had not been a markedly undernourished baby. She was born by caesarian section. It is interesting here that the patient does not describe any sensation of a band or localized 'brain stiffness' or head pressure feelings which are so commonly described by schizophrenic patients and by some neurotics, but rather feelings of light-headedness in her panic states, as though her head would 'fly to pieces', and a feeling of stiffness in the face. The last was definitely a reproduction of the chloroform mask and disappeared readily on analysis. That she was an uneasy infant from the very first was attested by the crying, excessive sucking, twitching and rubbing which began in the very first weeks, and the convulsions and easy deliria within

the first two years. The mother's constant watchfulness and tension almost certainly was reflected in her face [17] and in her handling of the young baby. The mother prided herself on taking care of the little one alone, in spite of her own emotional burdens and practical responsibilities at the time. The mother described the first few years of her childrens' lives as 'a hell of worries' to her. It does not seem to me too far fetched to consider that the patient's truly extraordinary sensitivity to facial expression, strikingly apparent in the first few months of her analysis, had its roots in this early period, although it may have been augmented in infancy by the birth of the somewhat mutilated sister and by her own abundant experience with anæsthesia. Subsequently it was sustained by a severe father who exerted much control through frowns and scowls.

Similarly the direct effects of the caesarian birth became amalgamated later with the images called up by the verbal accounts of it which she heard, and gave substantiating form to some of her later birth theories. We see further in this girl's birth a situation which favored a sense of abnormality and, with the death of the grandmother following so closely, gave rise to questions of her own identity, expanded her omnipotence even to the point of killing, and intensified her guilt feelings, etc.

For the *essential* neurosis two events were especially important: the birth of the younger sister, a mutilated half dead baby, when the patient was twenty-seven months old, and a rape by a grown man occurring when the patient was five years old. The patient's own mastoid infection and operation, following so closely on the sister's birth, had psychologically the importance of birth to her, and the repeated experience with anæsthesia merged with her death and rebirth fantasies.

[17] Therese Benedek quotes C. Bühler as observing that the infant recognizes the face of the mother or nurse at an earlier age than it recognizes the bottle. She draws the very pertinent conclusion that the confidence inspired by this recognition is a stage of object relationship preceding positive object love. This regularly occurs by the third month. *Adaptation to Reality in Early Infancy.* This QUARTERLY, VII, 1938, p. 203.

It is interesting too, that there was a recurrence of the mastoid following the mother's miscarriage when the patient was about seven. The time of the birth of the sister was remembered quite readily by the patient, but its emotional significance was completely annulled in consciousness and had to be unfolded to her in analysis against the customarily stern defenses of the obsessional neurotic. For the rape, however, occurring as it did at the beginning of the latency period, she had a deep hysterical amnesia.

Summary

In presenting this clinical paper I have had to condense and simplify the material very greatly and have attempted only to sketch it in such a way as to indicate the fundamental outlines of the work. In the last case cited, the work began with the problem of management of the anxiety laden behavior and the establishment of a better grasp of immediate reality. The education away from narcissism extended throughout the entire analysis, permitting the patient an increasingly useful self-critique. The interpretation was gradually deepened until the essential neurosis could be reached. I believe that these general principles are applicable wherever there have been many severe and early traumata, whether or not there is any possibility of antenatal and natal contributing factors in the underlying anxiety.

This is a group of patients who are coming to analysts with increasing frequency, asking and needing help. It is clear that the consideration of these cases takes us back to the need for more observation with infants, work which appears to me the source of the richest material for psychoanalysis.

Before closing, I want to give due appreciation to the work already published by others dealing with many aspects of these problems. I think of the publications of Brill, Zilboorg, Sullivan, Schilder and others of about a decade or more ago; more recently there have appeared the publications of Hill, of Tidd at the Menninger Clinic, of Fromm-Reichmann and Bullard at Rockville; and in our own Society the papers of Stern, Franz

Cohn, Lorand, and Thompson. By and large these have dealt, however, with conditions as encountered in the franker psychotic states, or with relatively circumscribed problems of interpretation or of method. I hope that my own paper may serve to bring these observations and considerations together in a general form, and especially to demonstrate them in the severe neuroses or borderline states which so often occupy a sort of no man's land between the hospital and the analyst's office.

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NEGATIVE REACTIONS TO CHRISTMAS

BY JULE EISENBUD (NEW YORK)

The observance of great secular and religious festivals is in general marked by the individual's gratification of infantile wishes which are normally held in check by feelings of guilt. A festival is a social sanction to forms of enjoyment which at other times must be held to a judicious minimum.

The type of celebration that characterizes a festival has only a formal relationship to the generic meaning of the holiday. While legend and ritual lend the trappings, individuals react according to the peculiarities of their temperaments. Some merely indulge in immoderate eating and drinking; others look forward to unbridling their ordinarily monotonous sexual lives; exhibitionistic persons use a holiday as a pretext for jumping onto the stage; still others, according to their lights.

The converse of this type of reaction is to be seen in those persons who are unable to make the most of a celebration, must always suffer, must never for any reason discard their sackcloth. Here too, however, there is nothing specific in any particular festival which invites the negative reaction but rather the very idea of having enjoyment.[1]

Of all festivals, that marking the Christmas and New Year season is characterized by the greatest relaxation on the part of the superego of society, so to speak. This is the season when governments grant amnesties and penal institutions distribute pardons. It is the season when the solid citizen becomes liquid and 'the devil is raised'. When it is all over, repression resumes and the air is disinfected with good resolutions.

Instances in two persons of specifically negative reactions to the Christmas festival are recorded.

Read before the New York Psychoanalytic Society, Dec. 10, 1940.

[1] Ferenczi, Sándor: Sunday Neuroses, in *Further Contributions to the Theory and Technique of Psycho-Analysis.* London: Hogarth Press, 1926.

The first patient was a woman of thirty-four who came to analysis in May 1939, for a depression which had had its onset in December 1938, when she lost her job following a short period of conflict with the executives in a merchandising concern where she had worked for several months. In business circles the patient was known as a brilliant buyer but had the reputation of being as 'hard as nails'. Hated and feared by the men in the trade because of her independence and bullying tactics, the patient drifted from one concern to another in an erratic career. Because of her known shrewdness and ability she had always managed to have her choice of jobs, but sooner or later a tense and threatening disharmony which inevitably developed in any concern in which she was employed was ultimately traced to her wildly competitive raids into the provinces of other executives. She would find herself unemployed again, and for some reason things usually came to a critical pass just before Christmas.

The patient's love life had consisted of several intense homosexual affairs in which she was the active partner. For a depression following the loss of a homosexual love object she had several years earlier sought psychiatric treatment in another city where she was working. After one year this moderately intensive, nonanalytic treatment was brought to an abrupt end by the patient under conditions which she remembered vaguely. A report from the psychiatrist who had treated her was equally vague about the circumstances of the termination of treatment. The only clue was provided by the patient's strongly hostile attitude towards this physician and her insistence that he was a 'phony'.

The patient's depression was relieved almost immediately after she began analysis. She secured another position and began to enjoy a period of moderately good health. In analysis she was comfortable but unproductive. She very rarely brought dreams and kept a tight rein on her fantasy which had to be sensed from her transference attitudes. Her marked overvaluation of analysis and the analyst, her feeling that analysis was 'the real thing', her inexplicable sense of perfect security

and her tendency to identify with the analyst all pointed to the conclusion that she was living in fantasied possession of a phallic mother. So securely had she locked herself into this psychic position, so deep were her repressive entrenchments and so inaccessible did she render her fantasy that the tools of analysis were beginning to appear desperately inadequate for disturbing her defenses. Under such circumstances the analysis seemed to have reached an impasse; yet month after month went by without any change in the patient's serene detachment.

Early in December 1939, the patient started to show signs of wavering. She became annoyed with the usual Christmas advertising which was daily gaining momentum. She complained of the 'mass neurosis' which seized business at this season, asserting that in the long run business lost more than it gained. For her part she was determined to keep calm and not allow herself to be swept into overbidding the market; she did not want to wake up after the New Year to find a lot of 'useless and unsaleable' merchandise on her hands. Finally she began to indicate in rather paranoid reports of what was going on at the office that she was coming into conflict with the male executives of her concern, and that once again she was putting her position in jeopardy.

In the transference she began to express marked ambivalence, revealing strong unconscious efforts to dominate the analyst, to threaten him, render him impotent and control the analytic situation, coincident with an extreme intensification of a 'positive' transference which became so exaggerated as to have a quality of burlesque. At the bottom of this intensification was a frantic effort to preserve her introjection of the phallic portion of the analyst which had become somehow insecure. By way of reassurance she kept reciting to herself, 'The Lord is my shepherd; I shall not want. . . . Thy rod and thy staff they comfort me', the benign image of the analyst serving for the Lord.

The peak of her mounting anxiety was reached with the analysis of the patient's insistent demands that she be referred to a gynecologist for a cervical discharge to which she referred

delicately as 'the trouble with my lower extremity'. One of her first dreams which occurred at this time revealed an effort to fortify herself and to threaten the analyst with a leaking, phallic breast. The working over of this and related material led to the recovery by the patient of the following early memory:

> The scene was of a busy household in the confusion of preparations the day before Christmas. The patient, four at the time, was trying to get some attention from her mother who was flying about the place in a flurry of last minute duties and who kept putting the child off with some irritation. Finally the child was told that she must withhold her demands until Santa Claus came; that if she were a good little girl Santa would bring her anything she desired. That night, the patient remembered, she prayed to Santa Claus earnestly and ardently. She had only one wish and that was to be like her brother, two years older, the pet of the family and especially of the mother to whom the patient was nothing but a burden. If she were a boy the child suspected, she too could claim the mother's love; therefore she prayed that Santa Claus change her into a boy. She was confident that on Christmas morning she would awake to find the transformation accomplished.

At this point the patient's memory failed, but the rest of the tragic story was easily reconstructed. Out of her bitter disappointment on that fateful Christmas day was born the beginnings of disbelief and a lifelong philosophy of sceptical empiricism. True, for the next year or two the patient flirted with the idea of giving Santa Claus another chance to make good. In these succeeding years her wish for a penis, originally a key to her mother's love, was reënforced by the inevitable castration anxiety. But at length this wish, stifled by repression, ceded to rancorous hardheadedness.

The patient now related that she could not remember a Christmas which had been a time of joy and happiness to her; rather had it always been a time of anxiety and depression. This she had attributed to the fact that this holiday always

seemed to arrive in the middle of a series of misfortunes such as the loss of jobs or love objects; but on inspection this was seen to be the inevitable result of an annual preparation for disaster, a seasonal access in her assertion of power, masculinity and independence leading to open conflict with those for whom she worked, and strained relations with her intimates.

The patient now clarified the circumstances leading up to the abrupt termination of her earlier period of psychiatric treatment. At that time too she had developed a cervical discharge (a fantasied penis) just before Christmas. The psychiatrist referred her to a gynecologist who promptly cauterized the offending 'member'. The intense negativity to the psychiatrist which followed was quite beyond repair and directly after another black Christmas the patient, to use her own metaphor, uncermoniously 'pulled the whiskers off this fake Santa Claus' and took her angry leave.

This year for the first time in her memory the patient managed to absorb some of the Christmas spirit and to enjoy the gaiety of the season. Furthermore, her cervicitis disappeared as she became able to release a portion of her masculine strivings for service in more realistically productive channels.

The second patient was a single woman of twenty-eight whose phallic strivings were responsible for the development of a bizarre and disjointed personality. Always 'tough-mindedly realistic', a quality of which she was proud, the patient became more than usually acrid during the Christmas rush. The commercialism attending the holiday was revolting to her and she refused to participate. A special target for her withering comments was the preservation of the festival at a time when the world was at war and thousands of men were about to be 'hacked to pieces'.

The following dreams occurred at this time:

> The patient came into the analytic room where a horrible sight met her eyes. In the air next to the wall above the couch was something in the form of a snake with its downward pointing head so raised that it stuck out from the wall

horizontally. On closer inspection the patient saw that what had given the appearance of a snake was really a collection of droplets of blood suspended in the air and conforming to that shape. She inferred that a snake *must have been there* but had been destroyed and that now only the blood remained as a sign of its former presence. The patient then felt easier when she looked down and saw a pool of glue in the middle of the analytic couch.

In her castration anxiety the patient found reassurance in the simple fantasy that analysis would restore (glue) to her her long lost penis in place of which she now had only menstrual blood. The association which gave the dream seasonal relevance was the similarity of the shape formed by the droplets to a stocking. This reminded her of the stocking she had hung by the chimney as a child on Christmas Eve.

A further elaboration of this theme occurred in a dream a few nights later.

The patient came into what appeared to be a schoolroom decorated for Christmas. A man who looked like Santa Claus except for the fact that he was dressed in brown instead of red, was drawing on the blackboard the picture of the mythical sea serpent. He did a splendid job and all the girls in the class including the patient applauded excitedly when he finished. Santa Claus appeared not to be fully satisfied with his work and erased a portion of the serpent somewhere in the middle, perhaps nearer the head, and on its underside. But before he had filled in what had been erased he dropped the chalk abruptly and left the room to follow a woman who had gotten up to leave. To the keen disappointment of the patient the picture was left unfinished.

Without going into the detailed analysis of this dream, which highlighted the anal and intellectual penis equivalents to which the patient clung, we can nevertheless grasp the meaning in relation to the Christmas legend. And like many animal tales told to children which probably have similar origins ('. . . And that is how the chipmunk got his stripes'; '. . . And that is how the bear lost its tail'), this dream too is in the form of a legend

designed to dilute the bitterness of the dreamer's fate ('. . . And that is why girls never got penises'). Legend is the past history of destiny, and the belief in legend may spring, paradoxically, from the acceptance of reality.

In connection with the analysis of these dreams the patient's earlier description of the onset of her first menstrual period at age twelve came up for rediscussion. The patient remembered being upstairs in her room on the day before Christmas where she indulged in pleasant daydreams of the lovely gifts which would fill her stocking the next morning. She remembered fantasying a comparison between her anticipated haul and what her younger brother might get. He had always had 'more to play with' than she had. That afternoon, keyed up by heady fantasies, she broke a long standing moral resolve and gave way to an impulse to masturbate. What gifts she received the following day and what was the outcome of her competition with her brother was now completely gone from the patient's memory. All she remembered was that on that day her first menstrual flow had had its onset, terrifying her with the thought that she had injured herself in masturbation.

This had all the characteristics of a highly condensed screen memory behind whose chronologically telescoped drama lay a severe castration anxiety, an intense wish for a penis and the forlorn hope that Santa Claus would magically provide one. In the light of the repeated disappointment of this hope it is not surprising that the patient had long since come to look upon Christmas as a hateful season.

BOOK REVIEWS

THE NEUROSES IN WAR. Edited by Emanuel Miller. With a concluding chapter by H. Crichton-Miller. New York: The Macmillan Co., 1940. 250 pp.

The last World War became a war of nerves because it changed from a war of movement into a war of positions. Not only the acute instances of horror and shock in active warfare, but even more the inexorable element of 'time' proved an excessive burden to the 'nerves'.

In normal times, the psychiatrist in the army had been something of a luxury. His function lay merely in diagnosing the cases brought to him and in most cases, eliminating the patient from the army. During the last World War it suddenly developed that the 'psychic trauma' which a member of the fighting forces may have suffered, was of far-reaching importance, hardly secondary to physical injury. Many soldiers who had been found to be in good health physically as well as mentally at the time of their enlistment, showed symptoms of what was first called 'war hysteria'. Military psychiatrists, wavering in their attitude towards this nosological syndrome, could not make up their minds whether to consider the etiology organic or simply a matter of simulation. They were faced with the unfamiliar task of treating this host of war neurotics, curing them, and, if possible, returning them to active service.

Today we are engaged in another World War. Therefore it is of inestimable importance that at this moment there appears a book in which the experiences with the observation and treatment of war neuroses gathered during the last World War are compiled in a clear and systematic fashion. The importance of this is especially great as the present war is clearly destined to cause as yet incalculable ravages in the mental as well as in the physical health of the peoples involved.

The analyst will derive considerable satisfaction from the fact that this book is written entirely in the spirit of Freud. During the last World War those few of us who had already been taught the dynamics of the mental system by Freud, had to fight bitterly for the general recognition of the fact that mental disturbances

respond to objective study and treatment as well as injuries or organic disease.

A detailed survey of the literature of neuroses in war, in which psychiatrists have set down their experiences with 'war neurotics', is the foundation of the valuable book. My only objection is that my own first publication on such experiences during the years 1916–1918 is not included, a booklet entitled War Neuroses and Mental Trauma (published in 1918 by Nemnich at Munich). In this booklet I proved that the existence of war neuroses does not disprove Freud's assumption on the psychogenesis of neuroses, as was then maintained. On the contrary, a genuine war neurosis is always the manifestation of an individual instinctual conflict precipitated by the experience of war.

The 'survey of literature' gives the reader a fairly good idea of the far-reaching consequences 'shock' may have in the case of the individual soldier. Crichton-Miller writes: 'A bayonet attack, or the sight of the mangled body of a comrade, will arouse a horror in anyone, but will provoke a disproportionate reaction in individuals in whom there are pre-existent unrecognized conflicts over violence and aggressiveness. . . . During war not only was the general taboo on aggressiveness and violence diminished, but they were forced by military service into situations which inevitably stimulated the aggressiveness, and hence provoked anxiety. This anxiety is a signal of a threatened breakdown of defenses against aggressive impulses.' In his chapter, Mode of Onset of Neuroses in War, Milleis Culpin presents his observations on the transition stages from physical injury to hysterical conversion symptoms. He refers to the suggestive force of the faulty diagnosis, and does not fail to mention that 'the hysterical symptom is often only an excrescence upon a serious anxiety or obsessional state'. He concludes: 'A single hysterical symptom must not be regarded as more than a pointer to the general condition'. In the chapter on Clinical Case Studies, it is again the general principle to consider the symptom of the war neurotic as a disturbance of the personality as a whole. This is especially stressed in connection with the therapy. The authors mention cases where an indiscriminate application of the method of suppressing neurotic symptoms by hypnotic suggestion produced 'a regressive retreat into mental changes, even into an irreversible schizophrenic state'. All the authors stress the theoretically and practically vital discrimination between the pre-

cipitating factor and the deeper causal factor in the structure of a war neurosis. They all agree that physical strain and mental exhaustion rank among the precipitating factors, while the underlying cause is to be found in the more deep-seated, unconscious conflicts.

It is regrettable that the circumstances of war prevented the thorough analysis of some war neurotics, as, for instance, in the case of a soldier who suffered from vertigo and convulsions. 'After six months' strain, he saw a man suffer complete decapitation from a shell fragment.' The careful therapeutist, however, discovered that 'the soldier had a repeated "fantasy of a child being beaten", and that he had a strong father attachment of an ambivalent character'.

The authors investigate the relation of normal fear, in different actual danger situations, to the development of mental disturbances on the one hand, and to neurotic anxiety on the other. Emanuel Miller, in his chapter on Psycho-Pathology and the Theory of Neuroses in Wartime, presents a detailed study of considerable interest not only to the general psychiatrist but to the psychoanalyst as well. Especially interesting is his discussion of the discharge of aggressions in its relation to military discipline. Even the feeling of guilt, the relation of the soldier-ego to its superego, has not been neglected.

Of course a sufficiently large part of the book is given to the experiences gained by the different methods of treatment. Here the authors state that 'the difference between the neuroses of war and those of ordinary life have great therapeutic importance. Since the main causes are recent and objective in nature, superficial forms of treatment, which would certainly not be adequate to relieve the more deep-seated neuroses of ordinary life, are often sufficient to restore war patients to their former state of health. Left in the danger zone, most individuals become acclimatized; in others, especially the predisposed, the reinforcement of the stimulus perpetuates the disordered reactions to such an extent that removal from the recurrent stimulus is essential for cure. . . .' The author wisely adds that removal from the traumatic situation as a therapeutic factor is frequently insufficient, as in such a case there is conflict not between the patient and his surroundings, but an 'endopsychic conflict within himself'. For the application of hypnosis he recommends cases 'of simple anxiety, in which con-

dition is determined by a present-day situation'. It is of particular significance that the author applies to suggestion therapy the psychoanalytic knowledge about the ego structure which Freud has taught us. 'Suggestion is used to back the ego against the over-consciousness and false standards of the super-ego, and encourage the natural expression of such repressed tendencies as assertiveness and even of fear itself.' In cases where hypnotic suggestion is contraindicated, 'hypno-analysis' is recommended, and described by Hadfield. This hypno-analysis is applied according to the principles and technique Freud introduced in his first treatments of hysteria.

Maurice B. Wright discusses other psychotherapeutic methods. He recommends a combination of 'persuasion, reassurance and re-education' for all the many cases where psychoanalysis, even in a modified form, is unnecessary or impossible. That the author does not abandon his purely medical attitude even in the question of military discipline, is clearly shown in the following remarks: 'The question of discipline as a therapeutic measure is important'. And, later: 'If the patient resents discipline, then this resentment must be analysed, so that he may realize its significance.'

In the chapter The War of Nerves, W. R. Bion communicates to us his interesting views on 'civilian reaction, morale and prophylaxis'. The author investigates problems of mass psychology and the psychological tactics of the enemy, aiming at the paralysis of normal fear reactions. He investigates the differences of the mental situation between the soldier, an active participant in the fighting, and the civilian population passively exposed to a bombardment. This chapter is based on a thorough knowledge of mental stress and mental conflicts.

It is, of course, only natural that the book as a whole leaves unanswered some questions which are of particular interest to the psychoanalyst. I refer for instance to the unconscious castration fear, certainly the nucleus of most neurotic anxiety reactions of the soldier. Also, the classification of the individual neuroses does not always agree with the psychoanalytic concept of them. This, however, does not diminish the value of this excellent book, which is not intended to be a psychoanalytic treatise but merely a guide for the military psychiatrist.

I am certain that the book will fulfil its purpose: to help the fighting armies to heal the mental wounds of its members and thus

to enhance their fighting force. It will help the individual war neurotic to get well, and to fill the place his mental health permits him to occupy. It will help the threatened civilian population to protect itself against the assault on their nerves. Last but not least, the book should be studied by all who practise mental hygiene and whose task it is to protect public mental health. This book points out the mental dangers threatening a population as an aftermath of a war such as the present one.

No physician who has read Dr. Miller's valuable book will be troubled by the conflict which beset many a psychiatrist during the last war: the conflict over deciding which of the two is of the greater importance: the proper treatment of war neurotics, or the need of the army for a sufficient number of men.

ERNST SIMMEL (LOS ANGELES)

DAS PSYCHOANALYTISCHE VOLKSBUCH (The Psychoanalytic Popular Reader), Volume I, II of *Bücher des Werdenden* (Books of Evolution). Edited by Paul Federn and Heinrich Meng. Third extended and revised edition. Berne, Switzerland: Verlag Hans Huber, 1939. 733 pp.

This book is an attempt to present to an interested and intelligent public of laymen the discoveries and theories of Freud. Considering the difficulties of such an undertaking, one may say that this attempt is a success. The contributions of Aichhorn, Alexander, Federn, Jekels, Jones, Landauer and Meng—to mention only some of the authors—live up to the highest standards of popular presentations of scientific subjects.

It is however doubtful whether it is wise to present to a public of laymen the entire structure, including the controversial areas, of a science such as psychoanalysis, which is still in the process of growth. One should in any case mention that certain theories are contested by important groups of full-fledged psychoanalysts in good standing. To include, furthermore, problems of only theoretical or technical interest can only add to the confusion and the resistance of the lay reader.

The book is divided into four parts.

In part I, Psychology, Landauer, developing the concept of death instincts, does not mention a word about the difference of opinion on this subject among psychoanalysts. Alexander's defense against the 'reproach' of pansexualism is not effective either. His

argument (p. 117) is that it is the fault of society that sexuality is so important, because society laid such a strong ban on sexuality. But he does not say what other impulses there are which could be repressed by society, nor does he explain why the sexual impulses were singled out for repression. As a matter of fact one could point out, if one believes in the existence of a death instinct, that it is still more repressed than the sexual impulses. The only honest attitude would be to admit that until now psychoanalysis, as the science of the psychic unconscious, has as yet not detected with certainty anything but libidinal contents in this unconscious, and that the assumption of other impulses, the death instincts, is based rather on theoretical deliberations and loans from biology than on direct psychoanalytic observation. But whether it is practical to present at all such a disputed matter to the judgment of a layman who has no other basis for judgment than introspection, is more than doubtful.

Jekels presents (pp. 83 ff.) Federn's theory of the ego-object relations. This theory is very interesting and may become fertile for the further development of theoretical ego psychology. But I doubt whether the layman will profit very much from such concepts as 'cathexis of the ego boundaries' or 'extension and contraction of the ego boundaries'. A simple explanation that our attention oscillates between objects, body and ego might have conveyed a better understanding. 'Cathexis' is a quantitative energic term which remains purely theoretical as long as we have no means of measuring libidinal quanta.

It might be said of the entire part I (psychology) that the desire of the editors to present the whole of psychoanalytic psychology and its theory is in conflict with the main purpose of the book to be a popular introduction to the science. Less would have been more.

Part II, Hygiene, is the best part of the book, thanks to the clear presentation of one contribution by Aichhorn and three contributions by Meng. Federn contributes a section which ought to be most helpful for people struggling with neurotic sexual symptoms. Discarding intricate theory he deals in two chapters with the physical and mental hygiene of sex life without presupposing any knowledge of these things on the part of the reader. In these chapters there is a deep and genuine promise of help for those who suffer without knowing why.

Part III deals with pathology. Here a general pathology which sought to acquaint the layman with the broader aspects of the symptomatology of neuroses and psychoses might have been better than the authors' attempt to present the special pathology of disorders like hysteria and compulsion neurosis. An exception is the contribution of Meng (The Psychic Diseases of the Child) in which symptoms are discussed rather than circumscribed neuroses. A similar chapter about the symptomatology of adolescence and adulthood might have been better and shorter.

In Hollos' contributions about psychoses one misses even a bare hint at the hereditary and constitutional factors involved, and the layman who is told that the whole story of psychosis can be explained in terms of regression to infantile fixations, is being given a very one-sided picture indeed.

In Part IV, The Science of Culture *(Kulturkunde)*, one misses contributions of such outstanding authors in this realm as Theodor Reik and Géza Róheim. The chapter about dissenting schools would be entirely satisfactory if the discussions of Bleuler (especially the point where he departs from psychoanalysis) and W. Reich (whose important contributions to psychoanalytic technique are not even mentioned) were not so incomplete. The contributions of Jones (Psychoanalysis and Religion) and Sachs (Psychoanalysis and Poetry) show the clarity and mastery of subject to which we are used with these authors.

CARL M. HEROLD (NEW YORK)

THE INTEGRATION OF THE PERSONALITY. By Carl G. Jung. New York and Toronto: Farrar & Rinehart, Inc., 1939. 313 pp.

The chapters of this volume were originally given as lectures at the Eranos Meeting at Ascona, Switzerland, and deal specifically with a process which the author calls 'individuation', defined as 'the psychological process that makes of a human being an "individual"—a unique, indivisible unit or "whole man"' (p. 3). His now famous concept of the collective unconscious is discussed in great detail. The book is written with a casual display of erudition that is at times somewhat staggering.

Jung discusses briefly Janet's and Freud's concepts of the unconscious, stating that according to both theories 'the unconscious is little else than psychological material that happens to lack the quality of consciousness, though it need not do so, and that differs

in no other way from conscious contents'. This is a rather surprising statement and certainly cannot come from the author's unfamiliarity with the freudian concept of the unconscious. One need but read his early The Psychology of Dementia Praecox [1] and recall his earlier work in Bleuler's clinic. It is perhaps of some significance that he further adds that both Freud and Janet base their theories on cases of neurosis and that neither of these authors had any psychiatric experience. In a footnote he states: 'The first time Freud applied his point of view to a psychosis was in the famous Schreber case (1911) to which I had called his attention.' Curiously enough, the author states in The Psychology of Dementia Praecox (p. 28), 'In 1896 Freud analyzed a paranoid condition, Kraepelin's paranoid form of dementia praecox, and showed how the symptoms were accurately determined according to the scheme of the transformation mechanism of hysteria. Freud then stated that paranoia, or the group of cases belonging to paranoia, are a defensive neuropsychosis.' The reviewer emphasizes this point for the 'record', if nothing else.

There are certain parallels to the process of individuation, of which, according to the author, gnosticism bore a most striking resemblance in its symbolism. In alchemy he discovers the requisite mediæval exemplar of the concept of individuation and he devotes the fifth chapter to a discussion of this idea.

Nowhere is Jung's allergy to sexuality more amply demonstrated than in the second chapter of this book, A Study in the Process of Individuation, in which he reports on a fifty-five-year-old female patient, according to him neither morbid nor neurotic, who executed a series of paintings which is reproduced in this book in five plates. It is difficult within the scope of a brief review to enter into a detailed discussion of the type of interpretation used. In relation to Plate IV one may use the author's own description: 'A black snake with golden mercury wings rears itself above the sphere and thrusts downward into it. Fire breaks out at the point of penetration. The mind wished again to suggest that the sphere repulsed the serpent; but the eye denies this. The sphere is red and blue, with a tripartite arrangement within: there are two green elements and one of gold. The kernel is surrounded by the silver of the mercury. A trinity is thus arrayed against the one, the

[1] Jung, Carl G.: *The Psychology of Dementia Praecox.* Nervous and Mental Disease Monograph Series, No. 3. New York, 1909.

serpent: the three in one against the devil, who is the fourth. . . . The devil is here also the animus, the one who is always right with respect to collective opinion, but who always gives false judgments in individual cases. This picture with its objective realization of important contents, led up to a turning point in the patient's psychic life. A climax was reached in her spiritual endeavours. To give her courage, I showed her a painting executed by a man, in which the serpent rises from below. This gave her a sudden light, and she understood that the whole process was impersonal in its nature. She seized upon the important truth that the ego is not the centre of psychic life; that it revolves around the self, the centre, like a planet around the sun; and that this is consonant with universal laws. The discernment of this truth played a decisive role in her later life' (pp. 37–38).

The third chapter deals with the collective unconscious along now familiar lines. There is a discussion of the hierarchy of the personal consciousness, the personal unconscious, and the deeper layer of the collective unconscious. The contents of this collective unconscious are the so called archetypes. There is a brief discussion of the symbols of transformation which portray the process of individuation: 'To the beginning of the process belong chiefly animal symbols, such as the serpent, bird, horse, wolf, bull, lion, and so forth. The serpent is a chapter in itself, for it has outspoken kinship in myth with the dragon, the black amphibian or reptile (in the diminutive, also the houseless wood snail and worm), the crocodile, the crab (in the diminutive, insects of every kind). The frog, on the other hand, . . .' etc. (p. 93).

Chapter IV deals with dream symbols of the process of individuation, and is based upon the first four hundred dreams of one patient, dreamed over a period of ten months. For the first five of these months the process was observed by one of Jung's women pupils, a doctor, under his direction, and then for three months the patient conducted the observations himself; so that three hundred and fifty-five of the four hundred dreams occurred without any personal contact with Jung. He emphasizes, quite rightly, that there is a great deal of popular misunderstanding about the interpretation of dreams. He states, 'We must renounce preconceived opinions in the analysis and interpretation of objective-psychic (so called "unconscious") contents' (p. 98). He proceeds with a dis-

cussion of the rules for dream interpretation, while admitting that the method followed in the study seems to run directly counter to his basic attitude towards dreams. The dream context is the important thing; 'but here we are dealing not with isolated dreams, but with several interconnected *series* in the course of which the meaning gradually develops to a certain extent of itself. *For the series is the context, and the dreamer himself supplies it* . . . so that the reading of all the texts is sufficient in itself to clear up the difficulties of meaning of each single one' (p. 101. Jung's italics). The third dream reported with the author's interpretation is characteristic to some extent of his technique: 'The subject "daydreams" that he is on the seacoast. The sea breaks into the land, overflowing everything. Then he is seated on a lonely island.' Interpretation: 'The sea, as earlier chapters have suggested, is the symbol of the collective unconscious because it hides unsuspected depths under a reflecting surface. Those who stand behind him, the shadowy and demonic *συνοπαθοί*, the "companions who travel along," have broken like a flood into the *terra firma* of consciousness. Such irruptions are uncanny because they are irrational and inexplicable to the individual concerned . . .' (p. 103). It is perhaps unfair to extract two items from a long and exceedingly complicated chapter. However, the rest of it must be read to be believed.

The fifth chapter, on the idea of redemption in alchemy, is perhaps the most interesting in the book. In it the author discusses the process and symbolism of mediæval alchemy and demonstrates the rôle that the projection of the unconscious played in the theory and practice of the mystic art. He particularly stresses the ritualistic aspect of alchemy and the emphasis upon the need for inner purity of the practitioner. He traces the identification of the *lapis* with the Christ figure and surmises that Christian symbolism was influenced by alchemy. It seems that as early as the 13th or 14th century, in the Codicillus, this passage appears: 'And as Jesus Christ, of the house of David, took upon himself human nature in order to free and to redeem mankind who were in the bonds of sin because of Adam's disobedience, so also, in our art, the thing that is unjustly defiled by the one will be absolved, cleansed and delivered from that foulness by another that is contrary to it' (p. 253). Of particular interest are the terms used by alchemists

and the description of the process, in which the incest motive plays an important rôle. A further quotation, from the Tractatus Aureus ascribed to Hermes, is of interest: 'Our most valuable stone, which was thrown upon the dung-heap has become altogether mean. . . . But when we marry the crowned king to the red daughter, then in a weak fire, she is gotten with a son, and he lives through our fire. . . . Then he is transformed, and his tincture remains as red as flesh. Our son of royal birth takes his tincture from the fire, whereupon death and darkness and the waters take to flight. The dragon fears the sunlight, and our dead son will live. The king comes out of the fire, and takes joy in the wedding. The hidden treasures are disclosed. The son, already come to life, has become a warrior in the fire and surpasses the tincture, because he is himself the treasure and himself bears the philosophical *materia*. Gather together, ye sons of wisdom, and rejoice, for death's dominion has found an end, and the son reigns, he wears the red garment and is clothed in the purple' (p. 253 ff.). His conclusion is that the alchemist projected what he calls the process of individuation upon the processes of chemical transformation and that this represented the projection of the archetypes from the collective unconscious.

In view of Jung's eminence in certain circles as a psychologist and leader of social thinking, the final chapter of the book, on the development of personality, will repay close study. It contains some of the choicest antidemocratic thinking to be found outside a Ministry of Propaganda and Enlightenment tract. In reference to a quotation from Goethe, the author states: 'It thus fittingly recognizes the historical fact that the great, liberating deeds of world history have come from leading personalities and never from the inert mass that is secondary at all times and needs the demagogue if it is to move at all. The paean of the Italian nation is addressed to the personality of the Duce, and the dirges of other nations lament the absence of great leaders' (p. 281). To this is appended the following final footnote of the book: 'This chapter was originally given as a lecture entitled *Die Stimme des Innern* at the Kulturbund, Vienna, in November, 1932. Since then Germany, too, has found its leader' (p. 305).

M. RALPH KAUFMAN (BOSTON)

BAUSTEINE ZUR PSYCHOANALYSE. (The Fundamentals of Psychoanalysis.) Four Volumes. By Sandor Ferenczi. Vols. III and IV published by Verlag Hans Huber, Berne, 1939. Vols. I and II published by Internationale Psychoanalytischer Verlag, 1927.

These four volumes embody a very conscientious and devoted attempt upon the part of the editors to make the *Bausteine zur Psychoanalyse* together with the *Versuch einer Genitaltheorie* a complete collection of Ferenczi's psychoanalytic works. Even notes left behind by Ferenczi as outlines for articles which he never put into form for publication are very carefully collected by the conscientious editors. The two new volumes include a number of Ferenczi's most significant papers, among which we may mention especially his papers on pathoneuroses and on the psychoanalysis of the war neuroses, his psychoanalytic comments on general paralysis, several of the papers developing Ferenczi's ideas concerning 'active' technical measures in psychoanalytic therapy, and all of the later papers dealing with Ferenczi's experiments in more complete abreaction of psychic traumata which absorbed the greater part of Ferenczi's interest in the last years of his life.

If we review the abundant scientific activity of these collected volumes, we cannot help being reminded of the tremendous fertility and versatility of this exceedingly stimulating leader in the development of psychoanalysis, who was continually dropping little hints upon one practical or theoretical topic after another, and whose suggestions covered such diverse themes as practical technical suggestions concerning active therapy, highly stimulating theoretical speculations concerning the evolutionary origin of the genital strivings, the influence of organic illness upon the psyche, an exceedingly suggestive paper upon the development of the sense of reality, and many others.

THOMAS M. FRENCH (CHICAGO)

FROM THIRTY YEARS WITH FREUD. By Theodor Reik. Translated by R. Winston. New York and Toronto: Farrar and Rinehart, Inc., 1940. 241 pp.

He who has not known Freud personally at all or who has met him only on few occasions will reach eagerly for a book the title

of which promises to bring that great man humanly nearer to his admirer. But he will be bitterly disappointed in Reik's book. In the preface Reik describes dramatically (and not without journalistic inflections) how the etching of Freud above his desk comes to life as he lays down his pen, interrupting his work, and looks up at the master's portrait. But that portrait, unfortunately, comes to life only for Reik; and it is the only thing about Freud that 'comes to life' in the whole book. Except for some verbal description of him and some short remarks about certain episodes which are scattered in the first two chapters we read little about Freud but a lot about Reik. We would be content not to be presented with a biography in this instance and would willingly 'dwell on Freud chiefly as a man and scientist', but we are less prepared to accept the author's suggestion that his (Reik's) 'own life and work and books . . . testify to what profound effect Freud's scientific work has had' upon Reik. The apparent theme of the book is: 'The achievements of the disciple are the laurels of the master' (p. 3).

Many of us who have ourselves experienced the profound effect of Freud's scientific work will feel that reading Reik's review of Civilization and Its Discontents (Chapter VI) and the not very staggering critical flourishes which he adds to The Future of an Illusion and A Study of Dostoyevski does not add measurably to this effect. To prove that Freud was able to listen to an understanding criticism (without giving in in essentials) and be nice about it, a few characteristic anecdotes might have been more effective than whole chapters of a disciple's scholarly arguments.

The last six essays in this book are a selection from essays which Reik dedicated and sent to Freud 'on his successive birthdays as a token of . . . [his] regard'. Outside of the fact that these pieces were birthday gifts to Freud, they have nothing to do with him as a 'man and scientist' and hence do not merit review in this place. Should they ever reappear in a volume with some title like Thirty Years with Reik, this reviewer, who has a high regard for some of Reik's previously published works, will be glad to give them due critical attention.

CARL M. HEROLD (NEW YORK)

FRUSTRATION AND AGGRESSION. By John Dollard, Leonard W. Doob, Neal E. Miller, O. H. Mowrer, and Robert R. Sears. New Haven: Yale University Press, 1939. 209 pp.

This book is a coöperative project which serves the valuable purpose of bringing into sharp focus the vital rôle of frustration and aggression in social problems. It does so by drawing on certain observations concerning frustration and aggression made by a number of authors, including Freud, systematizing these into a series of propositions, and then applying the theory to observations of the authors and also of many other workers upon a variety of sociological phenomena. One anticipates much from the application of psychoanalytic knowledge to these problems but some disappointment is perhaps unavoidable, for this is one of the first attempts by sociologists to apply to their own subject knowledge taken over from another field. The discussions of the various sociological themes, while stimulating, interesting and provocative, suffer from the attempt to set up and apply deductively a system which not only is not adequately proven or tested, nor based upon well-established psychoanalytic knowledge, but is even at certain points contrary to it.

The subjects reviewed are: Socialization in America; Adolescence; Criminality; Democracy, Fascism, and Communism; and A Primitive Society—The Ashanti. Although analysts will find little that is new in the interpretations, the application itself is interesting and illuminating, particularly as it is made in connection with the observations of many sociologists, psychologists, and other non-analytic workers. For example, the discussion of criminality brings out its aggressive elements as arising from frustrations in connection with economic, vocational and educational status, with the adolescent and postadolescent period, with inferior size, the position of minority groups, illegitimacy, the form of government, and so on. Some errors and omissions are perhaps unavoidable where considerable sections of work on such large fields are reviewed. For example, analytic writers on criminology are represented as concluding 'that all criminals are mentally disordered' (p. 138). This is a surprising misinterpretation of statements quoted in the text to the effect that '. . . delinquent and criminal behavior is instigated by psychological mechanisms (mainly unconscious) which are basically

similar to those believed to be operative in the neuroses and functional psychoses'.

The plan of the book is formulated in the introduction. 'It [the book] begins with a problem or a group of problems that are real in the experiences of daily life. As a first step towards the solution an attempt is made to define them more precisely, to explore their boundaries, to spot their essential facts, to formulate a system of concepts about these facts—in short, to develop a tentative theory or hypothesis that is based on the available data. This hypothesis is then used as a guide to further inquiries which are more precise and detailed and which yield data that are more systematic and closely interrelated. These data, in turn, are used for the further revision and refinement of the hypothesis. When this procedure of induction-deduction has been carried far enough it has been found, especially in the physical sciences, that the theory or hypothesis can be stated in mathematical terms. At this point the precision and power of mathematical methods may be employed and the theory approaches its fullest predictive value.'

The basic postulate is that aggression is *always* a consequence of frustration. A sample of some of the other propositions is the following:

> '1. The strength of instigation to aggression varies directly with the amount of frustration. Variation in the amount of frustration is a function of three factors: (1) strength of instigation to the frustrated response; (2) degree of interference with the frustrated response; and (3) the number of response sequences frustrated.
>
> '2. The inhibition of any act of aggression varies directly with the strength of the punishment anticipated for the expression of that act. Punishment includes injury to loved objects and failure to carry out an instigated act as well as the usual situations which produce pain.
>
> '3. In general it may be said that, with the strength of frustration held constant, the greater the anticipation of punishment for a given act of aggression, the less apt that act is to occur; and secondly, with anticipation of punishment held constant, the greater the strength of the frustration, the more apt aggression is to occur.'

It will immediately be apparent that these propositions are not only not statements of psychoanalytic knowledge, but are in part contradictory to it. Nor do the authors state how they arrived at these theories. It does not seem to the reviewer that certain cases of aggression can be described as the result of frustration without the use of excessive ingenuity. For example, that seen in paranoia as a

defense against an attraction, or as a defense against a disturbance of the personality organization, and so on. Moreover, simple self-defense when attacked is certainly not best described as aggression from frustration, unless the term frustration is used so generally as to severely dilute its meaning. As to the anticipation of punishment affecting aggression, Freud pointed out a mechanism now well recognized, that many individuals, both children and adults, become aggressive, even criminal, in order to get themselves punished because of their own unconscious sense of guilt. The risks of punishment certainly add to the attractiveness of crime as a career for many adventurous men. Alexander has pointed out the part played by the lag of the frontier ideals of individuality, independence and daring, in leading into crime as a serious career youths who now find themselves in a mechanized civilization which so little satisfies these ideals. It has been said that the church added a new zest to life when it made sex a sin. And so on.

No critical test of the system of propositions is made, but only the effort to demonstrate them in the situations examined. This demonstration is the significant part of the book, but certainly this objective would have been better accomplished on the basis of a preliminary statement of the well established and recognized psychological relationships, without attempting to set up a rigid system. For this is the effect, despite the announced intention of utilizing only a working hypothesis. Perhaps this system is warranted, but it exposes the work to the danger of making applications of hypotheses when these hypotheses themselves are not adequately tested, and when in fact they are not correct. The rigid system diminishes the value of the generalizations by giving them a precision of form which does not hold for the content. A system based so much on logic, however it may facilitate thought and help one find his way amidst complex observations, also runs the risk of constraining thought and observation. No room is left, for example, for the questions of aggression as a regressive satisfaction, or of its erotization, or for those considerations which led Freud to postulate a primary aggressive drive.

A few examples will illustrate how the great value of the demonstration of the rôles of frustration and aggression in social situations is diminished by the application of too rigid formulæ which lead to oversimplification and to blurring of the distinction between what is hypothesis and what is established fact. Race

prejudice is 'explained with the help of the present hypothesis' (p. 151). The explanation advanced is the well-known one of Germany's defeat in the last war causing hurt prestige, economic depressions, etc., with consequent aggression which finds an outlet against the Jews. But (p. 155) 'anti-Semitism had always existed in Germany and it was possible to resurrect and strengthen this traditional patterning'. The formula adds little and obscures such complexities as the reasons for the strength of this traditional pattern in Germany as compared with other countries, the relationship of anti-Semitism to homosexuality and the castration complex, the role of projection and of reaction against masochism, the specific as well as the general factors which involve not only the psychology of the anti-Semites but also that of the Jews and of the Jewish religion, and so on.

One wonders whether the goal of mathematical precision in the form sought for here is a possible one for this science. In anatomy, no mathematical formulæ can replace a knowledge of the structure of the body. To measure psychological impulses in individual cases and then develop the mathematical laws of their operation is a crying need of the science of the biological drives and of the emotional life—a need which we hope will be satisfied in the not too far future. But that mathematical formulae can be developed without the basic measurements seems doubtful and liable to lead not to increased understanding of reality and its laws, but away from it toward a realm of abstraction and to an overvaluation of thought and logic over observation and fact.

The failure of the attempt to set up a logic tight system will not surprise those psychoanalysts who see the importance of avoiding too early crystallization and formalization of theory in a young and rapidly developing observational science. Freud deliberately avoided this, keeping it a series of working hypotheses being constantly tested and revised through experience and new observations. It is not a correct representation of the content, method, or spirit of Freud's work, which is above all empirical and inductive, to say that he makes extensive use of a frustration-aggression *hypothesis*. The examples used in the text are from the discussions of the persistence of childhood emotions in dreams (in the Introductory Lectures) and are in no sense the inductive applications of a hypothesis. They are empirical observations, so commonly made that Freud says in discussing them, 'Why do I speak of these things,

so banal and so well known?' He, as all analysts do, saw in the observational material the significance of frustration, aggression and displacement, but did not consider this knowledge adequate for the erection or acceptance of any formal universal statements with which to work deductively. The only hypothesis concerning aggression developed by Freud is not utilized in this book. The analytic references, incidentally, are quite incomplete. For example, the aggressive element in wit is pointed out without reference to Freud's work, and the Ashanti are discussed without reference to Totem and Taboo.

This book is another sign of the application of psychological knowledge to sociological problems. It succeeds in its aim of placing '. . . within the common discourse such diverse phenomena as strikes and suicides, race prejudice and reformism, sibling jealousy and lynching, satirical humor and criminality, street fights and the reading of detective stories, wife-beating and war,' and in so doing, should prove of interest to both analysts and sociologists despite its serious limitations.

LEON J. SAUL (CHICAGO)

MUCOUS COLITIS. A Psychological Medical Study of Sixty Cases. By Benjamin V. White, M.D., Stanley Cobb, M.D., and Chester M. Jones, M.D. Psychosomatic Medicine Monograph 1. Washington, D. C.: National Research Council, 1939. 103 pp.

This extensive monograph on an old and perennially interesting disorder, for many years resident in the borderland of neurosis, consists of seven sections, preceded by a Foreword. The Historical Review traces thought about it from Woodward and Da Costa to the present. The second section (Clinical Syndrome), aside from the usual considerations implied by the title, emphasizes the frequency of low physical efficiency and the importance of evidence of dysfunction of the autonomic nervous system (without clearcut preponderance.) The presence of symptoms of increased tension in the physiological as well as the psychological activities of the *central* nervous system is also noted. The third section (Experimental Production of Lesions) surveys the experimental field briefly, with special reference to previously published work of two of the authors, concerning induced changes in the recto-sigmoid mucosa of normal medical students. The section on

Psychological Considerations (IV) occupies fifty-five pages. Its contribution will be mentioned below. Section V (Rôle of the Autonomic Nervous System) considers the autonomic physiology of the large intestine, deals at length with the Schneider and Turner tests of physical efficiency, and compares the personalities of patients with mucous colitis and bronchial asthma respectively. The sixth section (Therapy) deals with its subject under several headings and proposes a catholic approach, ranging from low residue diet to 'assistance in solving conflicts'. To the seventh section, the Summary, are appended a Glossary, largely of psychiatric terms used in the text, and a Bibliography.

The authors' own essential conclusions may be condensed and paraphrased as follows: the thesis is thought to have been developed that mucous colitis is a physiological colon disorder, dependent on parasympathetic activity. This is based on observed changes in the colon due to systemic effects of cholinergic drugs. (Stated with certain scientific reservations). Emotional tension is the most common source of the parasympathetic overstimulation. Predisposing to such tension are specific personality traits: overconscientiousness, dependence upon the opinions of others, and 'sensitivity'. Persons with such traits are thought to be specially disposed to anxiety when their egos are threatened, most notably by the danger of criticism. 'In this circumstance, they often experience the feeling of guilt.' They are also prone to develop extreme resentment when subjected to injustice, although their criteria of injustice may be distorted by their own overconscientiousness. The three most common emotions associated with tension in mucous colitis are: resentment, anxiety, and guilt, with resentment preponderant. To the preponderance of suppressed resentment is ascribed the dominance of parasympathetic activity. The duration of tension with its putative neurophysiologic effect is thought dependent on the duration of the patient's rumination on the pathogenic problems. Constant preoccupation with such problems is encouraged in many instances by a 'rigid obsessive method of thinking'. The stated personality characteristics, 'tension, anxiety, resentment, guilt, sensitivity, and rigidity of thought', are present with almost equal frequency in the 'more neurotic' and 'less neurotic' groups of patients. (These are separated by the presence of 'more or less incapacitating personality problems', i.e., manifest psychiatric symptoms, excluding the intestinal dis-

order.) The 'more neurotic' patients do not conform to a standard nosologic group but present anxious, obsessional, and phobic symptoms. An acute or chronic *tensional state* is the nearest to a common denominator. Hysteria is of minimal incidence. There is a close association between 'conscious and emotional' (conscious emotional?) tension and symptomatic exacerbation in the 'less neurotic' patients, less striking in the 'more neurotic'. A variety of physiological and pathological conditions are thought to predispose the organism to the development of the characteristic lesions. 'Symptoms arise when an unfortunate combination of psychological and physiological events cause morbid functions.'

Certain specific findings presented within the text are interesting. No correlation with body type or 'temperamental warmth' is apparent. A high incidence of sexual 'indifference' is observed. Minor compulsions are frequent; no compulsions are major problems. Incapacitating obsessions are not present; rigidity, rumination, and indecisiveness in thinking are common. There is a general impression that 'the tendency toward excessive neatness, compulsive completion of tasks, meticulous care in avoiding errors, and overconscientiousness in meeting obligations was distinctly a characteristic of the group'. Minor phobias are frequent. Depressive tendencies of vague type and lability of mood are frequent. 'Secondary gain' is negligible. In the character grouping (according to E. Kahn) there are no conspicuously independent characters; a high degree of 'ego dependence' is present in a large number of cases; the remainder are normal or 'ambitendent'. The attempt is made to correlate and compare these character types with the gastric, colon (colitis?), and constipation types of Alexander, with correlation between the diarrhœa and constipation phases of mucous colitis and what are regarded as the corresponding character types. Some basis for character differentiation in upper and lower gastrointestinal disease is corroborated and some special case material adduced to support this. In Rorschach tests on twenty-three patients, the essential findings are: (1) small number of whole responses; (2) movement seldom noted; (3) slight but inconsistent increase in color response; (4) certain types of response supporting the impression of rigidity of thought and lack of imagination.

In the psychological section, the authors eschew the methodological extremes of psychoanalysis and the mere chronology of social mishaps. They select a middle course in which a fairly

adequate anamnesis of each patient is taken and his current mental status described in detail. The personality studies are based on the classifications of Eugen Kahn. It is frankly stated that no attempt is made to study unconscious phenomena in any of the patients. The omission of the psychoanalytic approach is principally a matter of expediency (because of statistical volume), yet apparently not without an enthusiastic belief in the special value of the type of personality study employed. Having begun with this point of view, however, the authors would have done better to have consistently maintained it, to the exclusion of the psychoanalytic references, comparisons, and attempted correlations in the paper. The effort to tabulate together basically different concepts such as those of Freud, Kahn, Kretschmer and Adler in one instance, and Alexander, Kahn, and Adler in another, is superfluous and can lead only to the confusion which the authors 'risk'. The wish for a single-minded approach is expressed, although the present writer believes that careful psychoanalytic study of a single patient with mucous colitis must yield vastly more than many 'cross-section' studies in the direction of deep understanding of the character development, the incidental neurotic symptoms, the reaction to the current situation, and the presenting intestinal syndrome, all of which must be dynamically and genetically related, in so far as the emotional factors are at all important. A clear-cut descriptive and anamnestic presentation of the adult personalities and experiential reactions of individuals with a given somatic syndrome has unquestionable value which may be enhanced as time goes on by the increment of more fundamental (i.e., psychoanalytic) study, just as gross pathological anatomy increases in meaning and usefulness through histopathology and pathological physiology.

From the structural and rhetorical point of view, the monograph, can not be considered beyond criticism. It is often poorly organized and can be read and followed only with difficulty. Literal or inferred non sequiturs are disturbing. There is much repetition, and the repetitious material more than once fails of exact congruence in a disconcerting manner. Failure of correlation with anthropological types is mentioned on page 7; yet 'anthropological habitus' is listed on page 95 as first among the factors which 'play an important rôle in the development of susceptibility to these changes'. The numerous classifications, subclassifications,

quantifications, and graphic representations are occasionally interesting, sometimes rather specious, especially when they deal with material which does not naturally lend itself to such presentation. Where the incidence of compulsive symptoms is graphically represented in the 'more neurotic' and 'less neurotic' groups, the patient is apparently confined to 'none', or 'checking doors', or 'checking lights', or 'fussy about clothes' or 'reading letters twice', or 'upset by crooked pictures'. The use of vague or loose words and concepts vitiates the reader's sense of exact understanding and diminishes the impressiveness of theoretical constructs. The latter also suffer from their foundation on exclusively conscious symptomatic phenomena. Even definitions are not above reproach. Projection (in the Glossary) is 'the psychological process of placing at the door of another the responsibility for one's own inadequacies'. 'Obsessive thinking' is treated as a sort of neologism. A confused polemical attitude toward actual or putative psychoanalytic ideas is especially evident in the passages from pages 73 to 76. In contrast with these deficiencies, the presentations of case material are clear and interesting, and they convincingly establish the importance of the emotional factors within the limits set by the authors' method.

In general, the actual observations set forth in the paper are to be regarded as very valuable both in themselves and as stimulants towards further study. The authors recognize the need for psychoanalytic and further medical study of the problem. To the physician of psychoanalytic orientation, the frequency of minor compulsive and obsessive symptoms coupled with personality traits suggesting possible early anal difficulties gives strong impetus to the feeling that the ultimate choice of symptomatic expression is related to an infantile instinctual problem which probably entered into the very formation of the characters described, as well as their incidental neurotic symptoms. This impression is strengthened by the high incidence of disturbance of genital sexuality, admirably illustrated in some of the case presentations.

The section on Therapy would seem valuable from the point of view of the general medical man. Its psychiatric contribution is marked by much common sense. It is, unfortunately, marred by the type of verbal carelessness mentioned above.

LEO STONE (NEW YORK)

PSYCHOPATHIC STATES. By D. K. Henderson, M.D. New York: W. W. Norton & Co., Inc., 1939. 178 pp.

Every year a series of lectures is given by some outstanding psychiatrists at the New York Academy of Medicine in the memory of Thomas Salmon, a great pioneer in American psychiatry. One of the most important achievements of Dr. Salmon was his contribution to the organization and direction of the mental hygiene movement which has meant a great deal for psychiatry the world over. It may be assumed that these lectures do not follow the trends of orthodox psychiatry, but throw light on those disciplines with which psychiatry has close contact such as sociology, criminology, education, etc. This can be judged from the selection of such lecturers as Healy and Orton whose primary interests are delinquency and education respectively.

The present lectures deal with psychopathic states, the most baffling problem in psychiatry, criminology and law. The author, Dr. D. K. Henderson, is one of the leading pupils of Adolf Meyer, who has been responsible for the introduction of the principle of psychobiology into British psychiatry. The first lecture is entitled Place in Psychiatry and it deals with the problem of the psychopathic personality in its historical perspective. The author very wisely avoids a definition except in terms of social difficulties. The second chapter deals with the clinical aspect of the problem, and the third chapter outlines the author's recommendations.

The lectures are very easy to follow. They make pleasant and entertaining reading, and they must have been fun to hear. From the very beginning one is distressed by the extreme superficiality with which the subject is handled. It looks as though the author read quite a few references, pulled out a few interesting cases from his private files and the hospital record room, and then proceeded to express his thoughts on this interesting subject. Here and there he is fascinated by the ideas of various men, and he likes to quote Kahn who noticed that the hysterical patient is frequently egocentric and exhibitionistic. On the basis of this Kahn decided that the hysterical person is a psychopath in pure culture. This seems to appeal to the author a great deal. The gathering of the various points of view may be explained by the fact that the author is a good student of Adolf Meyer and does not subscribe to any one factor as being responsible for such complex phenomena as psycho-

pathic personalities. But here one misses the thoroughness and painstaking accuracy which is also characteristic of the psychobiological point of view. It seems the author knows something about analysis, but one has the impression that he knows more analysts than analysis. Unfortunately, these are frequently mixed up to the great detriment of analysis.

He points out that Kubie in one of his papers stated that analysis is still a very imperfect instrument and is undergoing constant evolution. He decides then that instead of utilizing the imperfect tool of analysis to explore the baffling field of the unconscious, he had better explore the conscious with the more perfect tool of psychobiology. This is a very good argument except that as a result of his exploration he has nothing to add to what we know. He recites a score of interesting cases over which he is thoroughly puzzled and he himself cannot understand in terms of heredity and constitution.

As a famous clinician and teacher, the author undoubtedly knows that the key to psychopathic personalities lies in the unconscious emotional life of these people; yet he does not even bother to go over the literature on this subject. To be sure, analysis is still a very imperfect tool of research; but a spyglass was a great advance in astronomy as compared with observations of the motions of stars from deep holes in the ground.

The author speaks about being 'dynamic', but somehow the reviewer fails to find a dynamic point of view in his actual discussion of cases. The handling of the material is somewhat anecdotal in character, even to the point of expressing great admiration for Lawrence of Arabia without which no good discussion of psychopathic personality is ever complete.

Even if the author is somewhat sketchy in the presentation of the clinical aspects of the problem, one must admire the astuteness of his observations, such as the one on the frequency of suicides in psychopaths, a consideration which is usually forgotten. One cannot help but agree with the author that psychopathic personalities cannot be treated as isolated phenomena and that a good deal depends on fundamental changes in our forensic and legal points of view. His recommendation for treatment of psychopathic personalities in institutions is certainly sound.

The book is well published but the references are not as pains-

takingly done as they usually are in similar monographs. Some of the authors mentioned are not found in the references and sometimes the authors are cited with the volume but without the title of the article.

J. KASANIN (SAN FRANCISCO)

TECHNIQUE OF ANALYTICAL PSYCHOTHERAPY. By Wilhelm Stekel. Translated by Eden and Cedar Paul. New York: W. W. Norton & Co., Inc., 1940. 408 pp.

This book is a translation of the German original which was published in 1938 in Berne, Switzerland, and which was reviewed in this QUARTERLY, Vol. VIII, No. 4, 1939. It is a literal translation from the German and nothing new about the text proper can be added. But the English edition is provided with a glossary. A publisher's note on the jacket draws attention to the glossary referring to '. . . the author's special uses of the more familiar medical terms, and . . . his valuable neologisms, which will hardly be found in the latest medical dictionaries'.

This glossary is interesting in many respects. There are many borrowed terms for which Stekel claims authorship. Theodore Reik's 'surprise' is launched by Stekel under the flag of 'analytical experience'; Laforgue's 'scotoma' is taken over unchanged without mentioning Laforgue. He does give credit for having coined the terms 'functional dream' and 'functional symbol' to Silberer, but Silberer is dead.

Other concepts Stekel appropriates but rechristens: 'organ speech of the mind' or 'somatization' are used for conversion; 'parapathy' stands for neurosis; a 'subjective-parapath' is what we call a narcissistic neurotic; psychosis is rechristened 'paralogia'; overdetermination gets from Stekel the colorful name 'polyphony of thought-processes'.

There are redefinitions of freudian concepts which would be amusing if they were not so deplorable. Thus we find under 'id' in the glossary the following: '. . . for Freudians, a quasi-impersonation of the unconscious Ego'. For Stekel who does not generalize the importance of the unconscious as does Freud, it is 'a quasi-impersonation of the pre-conscious Ego'.

That Stekel is not a logical thinker is proved by his definition of scotomization: '. . . mental blindness to what is going on within one's own psyche, identical with what the Freudians call repression'.

It is clear that repression is the process which *causes* mental blindness. In Stekel's definition cause and effect are declared to be identical. It is a tough job to replace good and useful technical terms.

CARL M. HEROLD (NEW YORK)

THE MECHANISM OF THOUGHT, IMAGERY AND HALLUCINATION. By Joshua Rosett. New York: Columbia University Press, 1939. 271 pp.

In this book Professor Rosett presents a sketchy, somewhat artificial and premature discussion of what psychologists and psychiatrists usually consider to be exceedingly complex functions. In his introduction Dr. Rosett bemoans the fact that the ancient and mediæval thinkers, also much concerned with the problem of consciousness, employed premises that were deeply rooted in fable and tradition. He complains that they 'exerted the powers of the mind in the vain hope that the factors requisite for the solution of the problem of the mind might thereby be obtained, the facts at their disposal thus remaining scanty. Their arguments contained wide gaps which they filled in by arbitrary assumptions of collosal magnitude and with the unbounded license of the poet and the dreamer. Most of them were indeed as much poets as they were logicians and they hardly ever hesitated to mix facts with phantasy.' In the reviewer's opinion, the author himself throughout the whole book lapses into a similar methodological procedure, often forgetting however that it is not simply the license which makes a good poet.

Rosett presents an inconclusive and not very scientific view of the problem in hand. The literature noted throughout the whole book represents only one small relevant part of the whole field of literature referable to the problems discussed. In the interests of brevity and perhaps simplicity a great deal of contradictory literature is omitted, the author thus sacrificing much that might have failed to fit in with his theories. It would be unfair to state, nevertheless, that the author has not drawn upon experience for his point of view; but he drew essentially only from his own experience which unfortunately was mainly in the safer, surer fields of neurology and neuroanatomy. The book therefore becomes more of a simplified introductory point of view for elementary students of the biological sciences rather than a thorough or profound

analysis of the problems of thought, imagery and hallucination as seen by the experienced psychiatrist or psychoanalyst.

That the book is ambitious in its attempted analyses of very fundamental problems may be seen from the chapter headings which are as follows: Part One: Fundamentals. I. The Law of Evolution and Dissolution of the Nervous System. II. The Emotional State. III. The Relation of the Emotions to the Conscious Sensory or Informative State. IV. The Expression and the Subjective Experience of the Emotions. V. The Will. VI. Nerve Signaling. VII. The Effects of Injuries of the Association Systems. VIII. Representation and Symbolism. Part Two: Mechanism. IX. A Definition of Thought, Imagery and Hallucination. X. Hallucinations in Certain Injuries and Diseases of the Nervous System. XI. The Epileptic Seizure. XII. The State of Attention. XIII. Sleep. Concluding Remarks.

It is hardly necessary to examine carefully each of these main subdivisions. Essentially the book presents a simple, mechanistic conception of complex psychic functions, along with a smattering of pertinent clinical and neurophysiological observations. Although one chapter is entitled A Definition of Thought, Imagery and Hallucination, it is exceedingly difficult to gain here or elsewhere in the book any definite conclusion as to what the author exactly means by these terms. This might perhaps best be gained from the statement that 'the activities of the functions of thought, imagery and hallucination in the order mentioned are conditioned by an increasing degree of inactivity of the sensory receptive apparatus and, therefore, by increasing amounts of disorientation in the present and relatively immediate surroundings', and further that 'thought, imagery and hallucination are, in the order mentioned, increasingly vivid and increasingly inaccurate subjective reproductions of objective experiences'. He feels that thought is inaccurate with respect to the definiteness of the mutual relations of the elements of the past experience. In imagery a more serious element of inaccuracy is introduced, namely, an error in relations; and finally, in hallucination the relations become so inaccurate that the past objective experience is very much distorted in its subjective reëxperience.

One example of the type of mechanistic approach used by Rosett may be taken from his analyses of the permanence of specificity of

the bodily changes resulting from temporary emotional disturbances. He states that each internal disturbance of the organism upon subsiding leaves a trace behind in the form of a more or less permanent organic change. 'For although it is true that the organism, after the subsidence of a disturbance, springs back toward its original state, that state is never quite attained, nor is it at all conceivable that the organism could by any possibility return to the exact point from which it was disturbed. Such a return would be possible only in the case of a body possessed of absolute elasticity and such bodies do not exist. . . .' Again, 'If the organism were to return after each disturbance to quite its original state, so that no trace of the disturbance were left, then each such successive disturbance would be a totally new event to the organism, separated from all preceding events by an impassable chasm and having no connection with them whatever.' Then he states that such a course is contraindicated by the facts and phenomena of memory and association. Likewise the author states that nervous impulses must affect the organism in the same progressive manner by building upon each successive impulse some trace of the preceding experience. This view, attractive as it seems, has apparently been arrived at much as Zeno arrived, at his paradoxes; the reviewer is unaware of any save rather gross, irrelevant experimental neurophysiological data which support it.

After reading the book, the reviewer was left quite at sea, concerning exactly what the writer means by the terms or functions for which he feels he has analyzed the mechanism. Besides in addition to being disturbed by numerous inaccuracies (for example, the confusion of the startle reaction or startle response with a minor epileptic seizure), the reviewer fails to recognize at what point the book presents any contribution of value either as a systematic approach to the problems of thought, imagery and hallucination or as an aid to the therapeutic problems of clinicians dealing with these functions.

The reviewer, personally acquainted with Dr. Rosett for many years, regrets greatly his recent untimely demise. He feels, however, that the subject of this book is too important to warrant the use of this review as a vehicle for a eulogy fully deserved by Professor Rosett for his other many valuable contributions to science.

S. EUGENE BARRERA (NEW YORK)

PSYCHIATRIC DICTIONARY WITH ENCYLOPEDIC TREATMENT OF MODERN TERMS. By Leland E. Hinsie, M.D., and Jacob Shatzky, Ph.D. New York: Oxford University Press, 1940. 559 pp.

According to the editors of this dictionary, psychoanalysis includes by definition: *'(1) psycho-analysis (Freud), (2) analytical psychology (Jung), (3) psychobiology (Meyer), and (4) individual psychology (Adler)'*. Whatever may have been the motive, this deliberate falsification has nothing to do with lexicography. The editors need only have consulted Webster's New International Dictionary, Second Edition Unabridged, 1939, to find a definition of psychoanalysis that says everything, is in accordance with the honest facts and has no axe to grind.

On the pages following the preface, a list of collaborators is printed. The Collaborator for Psychoanalysis is Trigant Burrow. Burrow's 'Lifwynn Foundation' and 'phyloanalysis' bear the same relationship to psychoanalysis that Dale Carnegie does to neurology. Going down the list, Jacob L. Moreno is found among a total of nine Collaborators to be the authority representing 'psychodrama' (q.v.).

This is a comprehensive dictionary with 7500 title entries. The definitions, however much one may disagree with their accuracy, are usually clearly stated. They are liberally illustrated by quotations with source references, many of which are unauthoritatively second hand (cf. *autism* which quotes Bridges and makes no mention of Bleuler). Dr. Hinsie is responsible only for the definition of terms used in 'descriptive psychiatry, psychoanalysis, analytical psychology, psychobiology, mental deficiency, sexology, nursing and social work' (p. V). The framework of the Dictionary is made up of psychiatric terms, but considerable attention has been devoted to terms in allied fields—clinical neurology, genetics and eugenics, social service for example.

The extent to which psychoanalysis has created and influenced current psychiatric terminology is very impressively revealed on almost every page. Accurate definition of psychoanalytic terms is frequently assured by extensive quotations from Freud or other psychoanalytic authors. Terms introduced as recently as 1939 *(egology)* are included; others much older (vector analysis) are ignored.

There is an unaccountable, inexcusable and irritating plague of

hyphens on these pages, giving currency to forms that are obsolescent and creating new hyphenated combinations. The hyphenated spelling *psycho-analysis* has never found acceptance in the United States. Rado, for example, gives his *riddance reflex* no hyphen and there is no reason why this dictionary should add one. The American usage is to omit hyphens with prefixes like *pseudo, post,* retaining the hyphen only in combinations with proper nouns and adjectives.

All the psychiatric curiosa and odds and ends are to be found in this dictionary but nowhere is gestalt psychology mentioned and the student tyro will look in vain to learn what a conditioned reflex is. *Behaviorism* however is included as are all the lush neologisms of the Lifwynn Foundation[1]. Every psychopathologist will agree that Pavlov's contribution is of infinitely greater significance for modern psychiatry than was Watson's ephemeral anti-psychological denial of consciousness. Not that Pavlov is completely ignored. Bafflingly enough, there is single entry: *Pavlov's theory of schizophrenia.* Dr. Moreno's cute *tele* [shorn of *pathy.* Get it?] and the *sociogram* are gravely considered, although *spontaneity theatre, Godhead,* and the *creative matrix* (Moreno) are mercifully if inconsistently omitted.

This adds up to something that does not equal scientific objectivity nor a good dictionary.

An unabridged, authoritative psychiatric dictionary that will become a standard work remains to be published.

R. G.

PSYCHOLOGICAL AND NEUROLOGICAL DEFINITIONS AND THE UNCONSCIOUS. By Samuel Kahn. Boston: Meador Publishing Company, 1940. 216 pp.

Purporting to be a glossary of neurological and psychological terms, this book is actually only an alphabetical list of 591 miscellaneous nouns, adjectives and eponyms such as might casually be remembered from extensive but careless and superficial reading, ranging from anatomy and surgery to clairvoyance and telepathy.

As for the definitions, intended by the author to cover 'the broader and larger aspects' of the terms, they usually contain some grain of truth, and are often lightened by unintentional humor or a unique use of words.

[1] *Cf.* This QUARTERLY, VI, 1937, p. 375.

Typical examples are: 'Circumstantial: Criminally, a person doing an anti-social act because of stress of circumstances. Mentally, an individual who postpones his goal idea and talks around the subject' (p. 78). 'Suggestibility, Degrees: Women are more suggestible than men, and girls more so than boys. Red heads are more sensitive to suggestion than blondes, and blondes more so than brunettes. Certain types of nervous people are more suggestible than normal people, and other types of nervous and mental patients are hardly suggestible at all' (p. 132). No explanation is given for such words as 'phantasizing', 'thelamus', 'irregardless', 'anual', 'pervertsion', 'convolusion', and 'spasmotic'. The author's grammar, like his orthography, is unique, and it is not possible to discover what laws of syntax, if any, were employed.

MILTON H. ERICKSON (ELOISE, MICHIGAN)

PSYCHOTHERAPY. By Lewellys F. Barker, M.D. New York: Appleton-Century Co., 1940. 218 pp.

The author, Professor Emeritus of Medicine at Johns Hopkins and as the dust cover informs us, 'one of America's most prominent medical men', has set out to tell us in this book what he has learned from thirty years of 'systematic' practice of psychotherapy. To this reviewer it appears that what the professor has learned adds up precisely to zero, and it is a great pity that he has elected to take 218 pages to document what he could have made clear in one brief, bald statement of fact.

Must we be told, for instance, that after thirty years the professor is still 'teaching' the neurasthenic 'to disregard disagreeable sensations, to avoid excessive strains and exhausting emotions [as if the neurasthenic does anything else] and to cultivate a state of greater confidence in his body'? Must it be made painfully clear to us that after thirty long years the kernel of the author's approach to 'paranoiacs' has boiled down to the following: 'It should be explained to the patient that he needs to understand others—their motives, personalities and reactions—better than he does; if he can be taught to study these, he may become more tolerant and be led to see that the ideas he has harbored have been misinterpretations'?

Not content to rest his case on a few sample expositions of theory and a case history or two for form's sake, the professor goes on—almost compulsively, we fear—to demonstrate in every depart-

ment of clinical psychiatry that experience is sometimes the worst teacher. Of homosexuality he writes: 'In treatment, avoidance of homosexual companions as well as sexual continence should be advised. Total abstinence from sex relations with a person of the same sex may here be as important as total abstinence from drinking in an alcoholic addict. In some patients, a more normal heterosexual interest may gradually be developed.' Of psychasthenia, for the understanding of which he expresses 'a great debt of gratitude to Raymond and Janet for their monumental work upon Obsessions and Psychasthenia (1903)', he writes: 'In my opinion, the majority of psychasthenic states, contrary to Freud's ideas of an infantile sexual origin, arise mainly because of the constitutional nature of the patients, though contributing causal factors in the environment should not be overlooked.' Finally, to psychoanalysis, a farcical procedure referred to as 'mental liquidation', he attributes most of the follies and dangers that have crept into the modern practice of psychiatry. Lest the reader come away with an unwarranted pessimistic outlook, however, Professor Barker puts himself definitely on record in the last chapter, The Future of Psychotherapy, as of the opinion that this folderol will largely drop out as the wonders of chemotherapy take over.

Discoursing on the benefits of occupational therapy, the author writes: 'Psychiatrists have often quoted Sterne, who said: "It is better to do the most useless thing in the world than to remain for a quarter of an hour without doing anything at all. Cultivate rare tulips, become an autograph collector, breed rabbits, be a fisherman, turn egg-cups, cut out silhouettes for your children, hunt butterflies, or collect postage stamps."' With this advice the reviewer can not in all honesty agree. Sometimes it is better, if one has an idle quarter of an hour, or even an idle week, to do nothing—absolutely nothing—not even write a book.

JULE EISENBUD (NEW YORK)

PSYCHISCHER BEFUND UND PSYCHIATRISCHE DIAGNOSE (Psychic Findings and Psychiatric Diagnosis). By Professor Kurt Schneider. Leipzig: Georg Thieme, 1939. 27 pp.

The author uses excellent formulations and an instructive case illustration to point out mainly to the general practitioner the steps from psychological findings to psychiatric diagnosis of schizophrenic and manic-depressive psychoses. Psychiatric diagnosis is

not simply an addition and combination of objective facts, but an evaluation of verbal communication, of behaviorisms and of more or less subjective observations and impressions. According to the author, a good psychiatric description also includes an analysis of the patient's behavior.

MARTIN GROTJAHN (CHICAGO)

TEXTBOOK OF NERVOUS DISEASES. By Robert Bing. Translated by Webb Haymaker from the fifth German edition. St. Louis: C. V. Mosby Co., 1939. 838 pp.

This is a useful compendium of the currently accepted syndromes of clinical neurology. The organization of the book is clear and the chapter headings and the index make it possible to look up rare constellations as readily as in a dictionary.

Its fundamental considerations of anatomy and physiology are limited in scope, but useful in a clinical text. The considerations of the psychoneuroses are archaic and devoid of value.

LAWRENCE S. KUBIE (NEW YORK)

MASTERING YOUR NERVES. By Peter Fletcher. New York: E. P. Dutton & Co., Inc., 1939. 241 pp.

The publisher offers this book to the public with the comment: '. . . it would be difficult to find a more satisfactory exposition of the fundamentals that psychoanalysis has been aiming at for many years'. Contradicting this pretentious comment the author writes in his introduction: 'My thinking and reading have convinced me that many of the accepted psychological theories are unnecessarily cumbersome, especially where the conception is involved of an almost autonomous, mysterious region of the mind called the "subconscious". My conviction is that what we most signally lack is a more adequate theory of consciousness . . .'

It is the author's liberty to develop a theory of consciousness if he so wishes, but to offer as a fundamental of psychoanalysis any theory which essentially rejects the 'unconscious' and regards it coldly as a mysterious region of the mind is license.

The body of the book elaborates themes such as secondary gain through illness, superiority feelings, avoiding responsibility, and so on, all without appreciation of basic dynamics of neurotic mechanisms.

Therapy is of dual nature: will-power and a belief in God. To break down the inhibitions and limitations of neurotic behavior the reader is advised to do things in a different way: 'Buy a different newspaper, go to the office by a different route, invite your business competitor to luncheon'. By such rules of thumb we are to discover new people and new things.

The last chapter is devoted to religion and the reader is told that 'It [faith in God] affords the only kind of reassurance by which the ultimate fears are exorcised and the ultimate trivialities overcome'.

WALTER BRIEHL (NEW YORK)

PSYCHIATRIC SOCIAL WORK. By Lois Meredith French. New York: The Commonwealth Fund, 1940. 344 pp.

This book is the result of a study of psychiatric social work undertaken under the auspices of the American Association of Psychiatric Social Workers aided by a grant from the Commonwealth Fund.

The study is comprehensive and a definite contribution to the field. The development of psychiatric social work as an integral part of the general mental hygiene program is traced from its forerunners and its first organized beginnings in a mental hospital (Boston Psychopathic Hospital) about 1912. The rôle played by the psychiatric social worker in the mental hospital and in the mental hygiene and child guidance clinics is discussed and there is a description of her activity extended to other areas, including the public health and educational agencies. The reader gets a clear picture of the underlying philosophy, methodology and the practical issues involved.

In formulating the trends in social treatment the author shows how the original concepts have inevitably led to the realization that modification of environment and the treatment of emotional problems are essentially inseparable and that the relationship between the social worker and client is the core of successful or unsuccessful treatment. The development of case work techniques to clarify and deal with this relationship and the influence of psychoanalysis in this connection are fully elaborated. As one reads the discussion of 'relationship therapy', 'passive technique' and 'attitude therapy' one cannot help wondering whether the social worker is still functioning within her field in engaging in such intensive types of personal therapy (some might even call it modified lay analysis).

However, the author is aware of this objection in her critical survey of the subject and leaves no doubt as to the experimental and controversial status of such 'social therapy'.

A chapter is devoted to professional education with consideration of academic and field work training. This book is of interest not only to social workers, visiting teachers and others with related interests, but also to psychiatrists and psychoanalysts, particularly those associated with psychiatric agencies or used as consultants in social agencies.

HERMAN SHLIONSKY (CEDAR GROVE, N. J.)

THE ART OF BEING A PERSON. By George Ross Wells. New York: D. Appleton-Century Company, Inc., 1939. 300 pp.

The author offers this book to the public in the hope that it may enable the reader to attain serenity, defined as a state of profound completeness, utter security and emotional satisfaction.

As subject matter he discusses interpersonal relations, social adjustment, marriage, parents and children and education—as well as fears, phobias and neuroses. The presentation of the latter themes will impress the reader who is at all familiar with psychoanalytic fundamentals only by its superficiality and oversimplification.

The chief merit of the book lies in the author's discussion of sociological problems and in this field he shows a good sense of values. Written for the laymen, this work offers nothing new to the specialist in psychotherapy. Notwithstanding its shortcomings, however, it may be classed as one of the better books among the great number which deluge the layman on the subject of personality development.

WALTER BRIEHL (NEW YORK)

AESTHETIC MOTIVE. By Elisabeth Schneider. New York: The Macmillan Company, 1939. 136 pp.

The author tries to build up her theory of æsthetics on a biological basis. She considers that in the course of evolution man loses much of his instinctive capacity, exchanging this for a greater adaptability to various outside changes. The result is a sense of insecurity, originating in an ambivalence of feeling toward any experience, since every experience in the outside world brings with it an alternation of attraction and repulsion. The æsthetic experi-

ence brings man a brief illusion of completeness, 'of knowing a whole', bringing with it a regression to the purely instinctive sphere of the prenatal existence. Art causes a regression to the purely instinctual level of experience (instinct in the sense of the German word *Instinkt,* not *Trieb*). From this standpoint the author examines the phenomena of natural beauty, imagination, genius, form and taste.

RICHARD STERBA (DETROIT)

HOW TO PSYCHOANALYZE THE BIBLE. By H. F. Haas. Orangeburg: S. C.: Haas Publication Committee, 1939. 116 pp.

The title is completely misleading. This is a very naïve exposition of the author's views on religion and what he thinks is psychoanalysis.

'If it is your desire to know and understand all about Heaven not as a supposition, belief, or desire, but as a downright fact, then simply psychoanalyze yourself in relation to your interest-object. The evidence will be first-hand, conclusive and irrefutable' (pp. 39–40).

GÉZA RÓHEIM (NEW YORK)

ABSTRACTS

The Concept of Psychic Suicide. A. A. Brill. Int. J. Psa., XX, 1939, pp. 246–251.

Brill reports the case of an old New England lady whose instinctive life had always been one of an anal sadistic nature. After the death of her manic depressive husband, and after the loss of her fortune, which was an especially hard blow for her, she refused to follow advice to undergo a medical examination. Some months later, before starting on a vacation, she gave up her apartment, put her furniture in storage, listed all her effects, drew up her will, and behaved in every respect as if she expected never to return. Two days after the beginning of her vacation, she fell ill and died of a cerebral thrombosis. The patient had never shown signs of melancholy. Nevertheless, it seems probable to Brill that the instinctive structure was very similar to that of a melancholia, and that her death is to be regarded as an equivalent of suicide.

OTTO FENICHEL

A Prefatory Note on 'Internalized Objects' and Depression. Marjorie Brierley. Int. J. Psa., XX, 1939, pp. 241–245.

Freud has warned us against using the psychoanalysis of a scientific adversary for polemic purposes. Nevertheless, it is interesting to investigate the psychological backgrounds of certain scientific antipathies or preferences. Brierley is of the opinion that emotional tendencies are chiefly operative in authors who doubt the theory of the 'internalized objects' (or some specific subdivisions of this theory). Since she is of the opinion that the reception of a hypothesis has 'quite a lot in common with the reception of interpretations', she tries to find the unconscious reasons for the criticism of 'internalized objects'. Persons who usually use projection rather than introjection as a means of defense have more difficulties in understanding this theory, she thinks, than 'introjectors'. Some authors react to the theory of internalization with anxiety because its acceptance would endanger their narcissistic unity. Others have become estranged from the archaic ways of thinking and living. Finally the author thinks that the criticism may be connected with anal repressions. 'One comes across a distaste for the "solid" nature of internal object terminology and a preference for thinking in the more "fluid" concepts of instinctual energy and affects that suggest painful anal reverberations.'

Brierley's paper does not discuss the correctness or incorrectness of the hypothesis in question.

OTTO FENICHEL

On Transference and Counter Transference. Alice Balint and Michael Balint. Int. J. Psa., XX, 1939, pp. 223–230.

No transference is 'ideal' in the sense that it is uninfluenced by the personality of the analyst and by events during analysis. The analyst may try to be

nothing but a mirror; he can never escape the fact that his own emotions determine entirely details of the way in which he proceeds. Nevertheless, the authors say, the various attitudes of various analysts have, if serious mistakes are avoided, equally good results. It should not be demanded that the analyst be free of emotions, but that he have the self-knowledge and self-control which is necessary to avoid 'serious mistakes'.

The reviewer would like to add one critical remark to his review of this excellent paper. The authors include the timing of interpretations, and, also in part, the content of interpretations among those attitudes which are dependent on the personality of the analyst, and which, they believe, cannot be determined by guiding principles. Certainly we agree that in these fields too there remain certain personal imponderabilia; but there is an objective doctrine of the dynamics and economics of interpretation applicable to all analyses.

OTTO FENICHEL

Psychoanalytic Observations on the Auræ of Two Cases with Convulsions. Ives Hendrick. Psychosomatic Med., II, No. 1, 1940.

In an extremely interesting and clearly written way a condensed report is given of psychoanalytic data showing certain determinents of the preconvulsive auræ of two patients. Limiting his conclusions strictly to the observations of two patients, the author states: 'In these two cases the auræ were conscious vestiges of neurotically precipitated anxiety attacks occurring before the onset of seizures. The repetition of these attacks was inhibited and in consequence of this, discharge through the central nervous system replaced the discharge of autonomic tension as an anxiety symptom. The relationship between the convulsions of these two patients and the preëpileptic anxiety syndromes are definite, and the function of the aura as an aborted tendency to repeat this experience seems probable.'

MARTIN GROTJAHN

The Correlations Between Ovarian Activity and Psychodynamic Processes: II. The Menstrual Phase. Therese Benedek and Boris B. Rubenstein. Psychosomatic Med., I, 1939, pp. 461–485.

Whenever heterosexual desire or a marked defense against it, made its appearance in the psychoanalytic material, estrone was produced in quantities sufficient to be recognized in the vaginal smear. Whenever the erotization of the female body markedly dominated the psychoanalytic material, progesterone activity was found in the vaginal smear. The psychic apparatus recorded incipient production of these hormones with extreme sensitivity. An abrupt decrease in heterosexual tension with an influx of passive libido (narcissistic erotization) characterized ovulation as proved by the vaginal smear and basal body temperature technique. The present paper is concerned with the premenstrual-menstrual phase which is the phase of diminishing and low gonad function. The correlations between these hormonal states and their psychodynamics are presented. The material was selected from a total of one hundred twenty-five cycles of fifteen patients. Instructive case material is given. The conclusions confirm the correlations of the first publication: the presence of

estrone corresponds to the presence of active heterosexual libido; the presence of progesterone corresponds to a passive receptive instinctual tendency. The early premenstrual period shows dominant progesterone, a recurrence of heterosexual tendency and mostly impregnation fantasies. The premenstrual period shows diminishing progesterone and oral incorporative and heterosexual fantasies. The late premenstrual period shows a sudden extinction of progesterone, with eliminative tendencies on genital or pregenital levels. The emotional tension or depression is out of proportion to hormone production. The menstrual phase of the cycle is characterized by low hormone activity and an emotional relaxation. The investigation confirms the probability that in the adult woman instinctual drives are related to specific hormone functions of the ovaries.

MARTIN GROTJAHN

Psychoses Resembling Schizophrenia Occurring with Emotional Stress and Ending in Recovery. Harry A. Paskind and Meyer Brown. Am. J. of Psychiatry, XCVI, 1940, p. 1379.

The authors describe a schizophrenic psychosis which takes place in a setting of a marked emotional turmoil and has a good prognosis for complete recovery. Their case material is limited to criminals who develop such reactions either immediately before or shortly after incarceration. They are thus related to the Ganser syndrome. The authors confess their complete inability to understand these cases. It is quite amazing that the teachings of modern psychiatry and psychoanalysis for the past thirty or forty years have never aroused the scientific curiosity of the authors, as shown by the following statement: 'It seems to us reasonable to believe that this psychosis resembles schizophrenia because they both involve the same mechanisms, whatever and wherever these mechanisms may be; and that the differences from schizophrenia (and these are related mainly to the course of the illness) may be related to differences in the etiologic agent—in these psychoses emotional shock—in true schizophrenia some other factor.' The references given in this paper look as if they had been copied from some continental textbook of psychiatry. The most important contribution to this subject made by J. Lange who wrote a special monograph on this same subject and published it in 1922 is not even mentioned. Similar contributions by American and foreign authors such as Henri Claude, Dunton, Sullivan, Kasanin and others have not been read by the authors; hence their statement that only four articles appeared on this subject in the past fifteen years.

J. KASANIN

The Relationship Between Early Schizophrenia and the Neuroses. Wilbur R. Miller. Am. J. of Psychiatry, XCVI, 1940, p. 889.

The author asks why some psychopathological reactions stop at the level of the neurosis and others progress to psychosis. In some cases it is a matter of underlying personality factors. In others, it depends on a defect in the method of handling disturbing experiences related to early instinctual life. The author postulates that there is a third group consisting of patients with

fairly stable personality organizations who under numerous stresses and strains resort first to a neurosis and subsequently to schizophrenia. In such cases the reaction is frequently reversible. To illustrate his thesis the author gives three cases. Unfortunately the cases do not illustrate very clearly the reason why the psychotic reaction developed as and when it did.

There is a rich literature on this subject which the author, outside of a dutiful reference to Adolf Meyer, has not even attempted to review. It is unfortunate that the author is not familiar with the article by Sullivan on Onset of Schizophrenia in which the same subject is treated with much deeper understanding and penetration.

J. KASANIN

Reconstruction Dreams. Max Levin. Am. J. of Psychiatry, XCVI, 1939, pp. 705–710.

The investigation of the mechanism of 'reconstruction dreams', that is of 'dreams in which a succession of events culminates as if by a marvelous coincidence, in a stimulus coinciding with an external stimulus of like nature which wakes the sleeper', is based on the terminology by Hughlings Jackson of vivid and faint images, a vivid image occurring when we actually see an object, a faint image when we merely think or visualize it. A dreamer may see in his dream what during the day he might only have been thinking. In a vivid image there is activation of all levels of the nervous system from the most primitive to the highest stages of evolutionary growth, whereas a faint image can function independently by 'representation'. The child in contrast to the adult is full of vivid images and relatively incapable of representation (faint images). The same is true in sleep and in psychosis, the highest centers no longer functioning independently of the lower ones.

The stimulus to a 'reconstruction dream' may arouse in the dreamer a faint image thus activating the substrates of the corresponding vivid image. The author offers no conclusive explanation why dream images seemingly antecede the stimulus which ultimately wakes the sleeper. As a partial answer he postulates that vivid images can be experienced only successively ('one can think of two colors simultaneously but not see two colors occupying the same space at the same moment'). Were the sleeper awake at the moment of the stimulus, he would experience faint images.

The author does not mention the dynamic and economic functions of dreams which serve the purpose of protecting the sleeper from disturbance of sleep.

MARGRIT MUNK

Charles Dickens in Oliver Twist. Ernest Boll. Psa. Rev., XXVII, No. 2, 1940.

Boll stresses the autobiographical character of Charles Dickens' novels, particularly Oliver Twist, and the effect of genuineness which is a consequence of what can be considered the author's own experiences. The author dwells on the personality of Rose Maylie in Oliver Twist, who is created according to the prototype of Dickens' sister-in-law, Mary Hogarth. Both wrestled with death at the tender age of seventeen. The death of his gentle, beautiful relative

unnerved the poet deeply and paralyzed his creative power for some time. The identification of the novelist with this dying girl is expressed in a letter: 'The recollection of her is an essential part of my being and is as inseparable from my existence as the beating of my heart is'. Mary Hogarth returns in the character of Nell in Old Curiosity Shop as a fusion of a self-image with Mary Hogarth. Nell's relationship to her extravagant, self-deluding grandfather is a sentimental reversion of Dickens' dissatisfactory relation to his own incompetent father. Boll recognizes that Dickens has mourned in Mary Hogarth the decline of his own youth; he threw off the paralyzing effect of this death through the characterization of young women in his novels.

The psychoanalyst might in addition be inclined to see in these sentimental female figures, Dickens' potentialities towards feminine passivity and masochistic surrender to the miseries of his childhood which he had to overcome by those creative activities that made him one of the most successful novelists of his time.

EDITH VOWINCKEL WEIGERT

A Case of Psychoanalysis with Poor Results. Samuel C. Karlan. Psa. Rev., XXVII, No. 2, 1940.

A patient with many psychotic trends but without a manifest psychosis was in psychoanalytic treatment 'by a reputable psychoanalyst, a member of the New York Psychoanalytic Society'. He later committed homicide and developed in prison a distinct acute psychosis. The author is of the opinion that the schizoid character of the patient should have been a contraindication to psychoanalysis. 'The writer believes that the psychoanalysis may have aggravated the patient's condition and led to the state of tension preceding the homicide.'

It is very regrettable that the analyst, who adds a 'critical comment', does not give his name. He is of the opinion that the whole character and the transference of the patient made analysis seem to be the treatment of choice. 'The fundamental problem of the patient was a profound passive homosexuality and a profound feeling of rejection by his mother.' It was 'a combination of untoward circumstances' which led to the unfortunate outcome.

OTTO FENICHEL

Sexual Manifestations in Neurotic and Psychotic Symptoms. A. A. Brill. The Psychiatric Quarterly, XIV, 1940, pp. 9–16.

Brill, in honoring Sigmund Freud, gives a short biography and defines some of Freud's technical terms, not for the psychoanalyst familiar with the subject but for the physician who is uninformed about Freud's psychology and is often misinformed about the meaning of special terms like ego libido, narcissistic libido, latency period, fixation, etc.

In order to give some insight into unconscious mechanisms and as a contribution to Freud's statement that, 'Delusional jealousy is an acidulated homosexuality and justly belongs to the classical forms of paranoia', Brill presents two case histories, the one of a paranoid schizophrenic with homo-

sexual trends, the other a case of overt homosexuality who, after a year of treatment, made a satisfactory heterosexual.

Brill states that many similar cases could be cited showing the course of libido development in the normal and in the neurotic. 'Viewing the psychoneuroses and the psychoses from the standpoint of Freud's libido theory, one not only obtains a logical and comprehensive picture of these maladies, but one also sees an entirely different picture of the child, the neurotic, the psychotic, and the pervert.'

J. I. STEINFELD

The Wish to Belong. Sylvia Allen. Bulletin of the Menninger Clinic, IV, No. 3, 1940.

The author states that in her work with patients she often asks the question, 'What is it for which you long?'. Though superficially the answers vary a great deal, she finds that the common theme throughout most of the answers is, 'a wish to belong'. Her paper is a discussion of the ways in which she has seen her patients attempt to satisfy this deep need. She finds that the wish to belong has a primary and a secondary aspect. In psychoneurotics, longings may be expressed in terms which are superficially normal and adult but which are really expressions of unsatisfied wishes of childhood. The primary aspect of the wish to belong is seen 'when the efforts to bring about a complete unity of these actual figures [personalities from childhood] is given up as an impossible task and a friendly relationship is established between the imprints of these figures in the personality of the individual. . . . The secondary aspect is fulfilled by the normal, ordinary daily social activities of human beings, the constructive features of which make up the cohesive force of society.'

CHARLES W. TIDD

Psychoanalytic Notes on Sleep and Convulsion Treatment in Functional Psychoses. Edith Vowinckel Weigert. Psychiatry, III, 1940, pp. 189–209.

In this paper attention is restricted to the psychological effect of sleep and convulsion treatment of functional psychoses. The physiological aspect of such treatment is omitted.

During sleep treatment the patients are more affectionate, erotic, and interested in the world of objects; more active, more accessible and consequently more tractable and sociable. The case report of a schizophrenic patient is given and the prolonged narcosis of this person with strong defenses against instinctual, particularly oral desires led to an alternation between oral object mutilation and depressive ego destruction on the one hand, and manic submersion of the superego and the ego with atonement and gratification of primitive desires on the other.

The effect of sleep treatment is milder than that of shock-treatment which leaves in the patient a memory of helpless surrender to the point of annihilation. Almost all patients experience it as a threat against life. The author asks the question: what distinguishes epileptic regression from the neurotic

or schizophrenic regression? While the schizophrenic, primarily hampered in his object-libidinal development, is bound to a more or less autistic recovery, the epileptic seizure which impairs transiently the ego functions forces him to a manic-like flight into a more or less delusionally transformed reality, with erotization and fears and clinging to objects. The panic provoked by shock (as shown in some detailed case reports) mobilized powerful erotization and turned the patient's interests from artistic fixations to external reality. Male patients showed a greater resistance. The tyrannical superego is replaced by attacks from reality, the ego tries to adjust to this reality more or less fortunately by new control and new repression. Sullivan's and Fromm-Reichmann's work with schizophrenics seemed to be much less dangerous than shock therapy and promise a deeper understanding of schizophrenics. Shock and convulsion therapy is opposed to the main striving of psychoanalytic therapy, to mitigate the cruelty of an archaic superego and to help the patient to endure the hardships of reality.

MARTIN GROTJAHN

Vigilance and the Vitalistic Hypothesis. Smith Ely Jelliffe. J. of Nerv. and Ment. Dis., XCII, 1940, pp. 471–488.

The author's paper is based on an impromptu discussion before the New York Psychiatric Society ten years ago. The paper presents a comprehensive discussion of the basic problems of psychiatry today and in the recent past, with special reference to the motor behavior of postencephalitic patients. The discussion, written in the author's well-known inspiring style, constitutes an important contribution to psychiatric methodology.

K. EISSLER

The Treatment of Illness of Emotional Origin by the General Physician. Edward Weiss. The Pennsylvania Med. J., December, 1939.

Thirty per cent of the general practitioner's patients suffer from functional illnesses, and the other seventy per cent are also influenced by emotional disorders; yet the organic tradition in medicine causes physicians more or less to despise patients with psychogenic symptoms or to treat them wrongly. Such patients should be induced to discuss their emotional problems freely. Often such communication alone is very helpful. 'It is a good rule for the physician to listen rather than to talk; to give advice on important emotional matters is dangerous.' In severer cases the patient should be sent to a specialist for 'major psychotherapy'.

OTTO FENICHEL

Dreams and Character. Alexander Herzberg. Character and Personality, VIII, 1940, pp. 323–335.

The author considers the dream 'a conscious occurrence during sleep' not caused by true perceptions. In his opinion dreams are caused by external or internal stimuli, impressions of the day before and 'more or less permanent feelings and volitions' such as ambition, sexual desire, hatred. From the study of an individual's dreams, the author believes that he can deduce the presence of certain

impulses and from these impulses certain character traits. He also concludes that by interpreting dreams in connection with other facts, such as actions, symptoms, etc., he can discover qualities of character unknown to the dreamer, such as sincerity and insincerity, aggressiveness, intensity of impulses and specific emotions. No reference is made to the work of Freud or to the psychoanalytic principles of dream interpretation except to allude to a few of the mechanisms such as repression and symbolism.

EDWIN R. EISLER

The Origin of the Signs of the Zodiac. Doris Webster. American Imago, I, No. 4, 1940.

The author has found a personal, intuitive approach to the conceptions of ancient and medieval medicine that associate the signs of the Zodiac with parts of the human body. Her method is to make use of words that emerge in the state of falling asleep. This 'functional phenomenon' was first studied by Silberer. Isakower, whom the author does not mention, pointed out that in the transition to sleep typical sensations show a preoccupation with the body ego. Similarly, the author's emerging words at the beginning of sleep ('spectral words') are linked by association with posture and sensations of the body surface. These spectral words gave to the author an understanding for the autosymbolization by which primitive men might have projected the body ego into the star groups of the sky that mark the course of the sun. It would be interesting to compare the author's intuitions with more detailed historic studies of the changing conceptions of the Zodiac.

EDITH VOWINCKEL WEIGERT

The Vicissitude of the Intellectual Immigrant of Today. Gregory Zilboorg. J. of Social Psychology, XII, 1940, pp. 393–397.

The present wave of immigration is characterized by an intellectual type of immigrant, in contrast to earlier times when the immigration represented predominantly the proletarian and lower middle classes. There resides a child within each of us and there is a longing for that psychological and symbolic extension of the mother image which we call our 'native land'. It takes time and spiritual work before one is able spontaneously and naturally to call a strange woman 'mother'. This is not a simile, it is a rather accurate, descriptive picture of the true state of the immigrant's psychology. The knowledge of the language is of outstanding importance. It is not enough to understand the words, for instance of the Gettysburg Address, but one must also spontaneously grasp the simplicity of it, its stirring humility, its spirit of mourning in the very glory of victory and its Christ-like universality of forgiveness.

MARTIN GROTJAHN

Die Ausdrucksbewegungen der Bejahung und der Verneinung. (The Expressive Gestures of Affirmation and Negation.) Yrjö Kulovesi. Int. Ztschr. f. Psa. u. Imago, XXIV, 1939, pp. 446–447.

Out of clinical experience with a compulsion neurotic patient Kulovesi draws the conclusion that the movement of nodding, expressing affirmation is a

derivative of movements having the intention of incorporation, especially of drinking. Shaking the head as expression of negation is a derivative of the movement of 'a child who refuses to take offered food into its mouth'. It is interesting to note that a paper published sixteen years ago in the *Internationale Zeitschrift für Psychoanalyse* offered a similar hypothesis.[1]

OTTO FENICHEL

Über die Beziehungen zwischen der psychoanalytischen und behaviouristischen Begriffsbildung. (On the Relation Between Psychoanalytic and Behavioristic Concepts.) Walter Hollitscher. Int. Ztschr. f. Psa. u. Imago, XXIV, 1939, pp. 398–416.

To bring about a mutual understanding between psychoanalysts and behaviorists, Hollitscher tries to break down the barrier between two branches of psychology by a logical analysis of the language used in behaviorism and psychoanalysis respectively. Explaining to psychoanalysts the point of view of logicians known as the *Wiener Kreis* he proves: 'It is quite possible to deal satisfactorily with the object of scientific psychology by limiting oneself to the description of the behavior of men and animals'. This thesis is known as Logical Behaviorism and should not be confused with the radical behaviorism of Watson. Most psychoanalysts feel that the reduction of psychological terms to objective words is quite unsatisfactory. Hollitscher feels that this dissatisfaction is due to nothing more than certain animistic magic ideas which are not yet completely eliminated from the thinking of psychologists. He then wants to convince behaviorists that all psychoanalytic language can be reduced to objective terms. It is only as metaphors that psychoanalytic terms contain more than objective facts. The psychoanalytic concepts are unfamiliar, abstract, and different from the psychological concepts of everyday language. Therefore the need for illustration, metaphor, and paraphrase is understandable. As an example he analyzes the concept of 'unconscious wish'. This concept may be substituted for instance by the following sentence in which every element of metaphor is avoided: 'The proposition: someone has this or that unconscious wish, means: he has the disposition under these circumstances to act in such or such manner, and in those to think and to talk in such or such manner, for instance to make this parapraxis, to experience these emotions and to have these free associations'. This paper is another indication of the increasing interest of psychoanalysts in the logical clarification of their method.

SIEGFRIED BERNFELD

The Choice of Organ in Organ Neuroses. Felix Deutsch. Int. J. Psa., XX, 1939, pp. 252–262.

The organ involved in an organ neurosis was first affected in childhood in connection with an instinctual conflict. Out of the psychic conflict and the function of the organ a 'psychosomatic unit' is created so that, if later the instincts in question become mobilized, the organ and the function thereof are

[1] Frankl, Viktor Emil: *Zur mimischen Bejahung und Verneinung.* Int. Ztschr. f. Psa., X, 1924, p. 437.

automatically mobilized too. This is demonstrated in examples relating to the respiratory and the circulatory systems. The earlier the 'psychosomatic unit' is created, the more rigid are the organ symptoms. Deutsch calls attention to the fact that the fixation of organ symptoms also depends on the attitude of the child's environment, so that three factors should be considered. 'If then the three factors coincide, the extrinsic organic factor, the personality organization at the time, and the action of the neurosis of the environment, the direction in which the choice of organ tends is definitely laid down.' The development of the symptoms depends on the interrelationship of these three factors so that, if all three factors are known, the course can be prophesied. Not very clear are the author's discussions about the relations between the organ neurotic symptom and the conversion symptom, which not only is the consequence of unconscious instinctual attitudes of the patient, but has a 'meaning' and expresses in a somatic form certain psychic ideas. Deutsch writes: 'We are inclined to believe that the difference between these two types is one of the degree of elasticity or rigidity with which the organic symptoms are bound to the neurosis'. Highly important ideas pertaining to this question were expressed by Freud in his early paper, Psychogenic Visual Disturbances According to Psychoanalytical Conceptions, which are too little heeded by authors who undertake to discuss these questions.

OTTO FENICHEL

NOTES

The NEW YORK PSYCHOANALYTIC SOCIETY and the New York Psychoanalytic Institute elected the following officers for 1941–42: President, Adolph Stern, M.D., Vice-President, Lillian D. Powers, M.D., Secretary, Philip R. Lehrman, M.D., Treasurer, Samuel Atkin, M.D. The following are the members of the Board of Directors: Samuel Atkin, M.D. (Executive Director), Carl Binger, M.D., Smiley Blanton, M.D., Leonard Blumgart, M.D., Isra T. Broadwin, M.D., Phyllis Greenacre, M.D., John A. P. Millet, M.D., Lillian D. Powers, M.D., Adolph Stern, M.D., Philip R. Lehrman, M.D. The members of the Educational Committee are: Samuel Atkin, M.D., Leonard Blumgart, M.D. (Chairman), Sara Bonnett, M.D., Lawrence S. Kubie, M.D., Philip R. Lehrman, M.D., Sandor Lorand, M.D., Lillian D. Powers, M.D., Sandor Rado, M.D., Adolph Stern, M.D., J. H. W. Van Ophuijsen, M.D., Fritz Wittels, M.D. Dr. Leonard Blumgart was elected to the Executive Council of the American Psychoanalytic Association and Drs. Philip R. Lehrman and Sandor Rado were elected to the Council on Professional Training of the American Psychoanalytic Association.

The courses of instruction for the academic year 1941–1942 of THE NEW YORK PSYCHOANALYTIC INSTITUTE are presented for the second consecutive year in a booklet that presents explicitly and comprehensively the courses, lectures and seminars to be given throughout the academic year. The courses are divided into two groups: I. Professional School (for training physicians in the therapeutic application of psychoanalysis); II. Extension School (for training in the applications of psychoanalysis to nonmedical fields). The concluding section of the booklet prints the revised regulations governing studies in the professional and extension schools of The New York Psychoanalytic Institute, and a list of psychoanalytic institutes and training centers in psychoanalysis in the United States which are recognized by the American Psychoanalytic Association and which have subscribed to its minimal standards.

The UNITED STATES CIVIL SERVICE COMMISSION, Washington, D. C., needs nurses with psychiatric training for duty in the Panama Canal Zone. For psychiatric duty, applicants must have completed a three-year course in a school of nursing in a psychiatric hospital and be registered as a graduate nurse. However, nurses who have had a three-year general nursing course and have had one year of experience on the nursing staff of a psychiatric hospital may also qualify for psychiatric duty. Applications will be accepted from persons in their final year of training in a nursing school although they must submit proof of the completion of the training course and registration as a graduate nurse before they enter on duty. Applicants must not have passed their thirty-fifth birthday. No written test will be given and applications will be accepted at the Commission's Washington office until further public notice. Further

information and application forms may be obtained from the Commission's representative at any first- or second-class post office or from the central office in Washington, D. C.

The FOSTER PARENTS' PLAN FOR WAR CHILDREN is operating twenty-five children's colonies in Great Britain today and is caring for more than 4,000 refugee children. Anna Freud is director of three of the Plan's nursery centers. Miss Freud and Mrs. Dorothy Burlingham have written reports of conditions and the care of the children in the Hampstead Nurseries. Limitations of space unfortunately prevent reprinting here the complete report. Especially interesting is the inclusion in the report of the brief clinical history of a boy who developed a rather severe neurosis after being separated from his mother. This was cured in a short time by arranging to bring the mother to him. The authors conclude: 'The interesting point about this story is that it does not seem to be the fact of separation from the mother to which the child reacted in this abnormal manner, but the traumatic way in which this separation took place. Patrick could dissociate himself from his mother when he was given three or four weeks to accomplish this task. When he had to do it all in one day it was a shock to which he answered with the production of symptoms. That means that even children with neurotic possibilities of Patrick's kind could be spared much unnecessary suffering and symptom formation by more careful handling.'

The SALMON MEMORIAL LECTURES which Dr. Robert D. Gillespie, psychiatric specialist of the British Royal Air Force will deliver in several cities of this country and Canada, have been announced by Dr. C. Charles Burlingame, chairman of the Salmon Committee on Psychiatry and Mental Hygiene. Dr. Gillespie has received special leave of absence from the RAF from the British government for the purpose of delivering the Salmon Lectures in this country and Canada. He will fly here to make a first-hand report to members of the American medical profession and officers of the United States Army and Navy Morale Division on the psychological effects of 'Blitz' warfare on civilian and armed forces.

The schedule for the Salmon Lectures is as follows: New York, November 17, 18; Toronto, November 19; Chicago, November 21; New Orleans, November 22; Washington, November 24, 25 (not open to the public); San Francisco, November 27; Philadelphia, November 30.

Dr. Gillespie will discuss the problems of psychiatry in national defense under the title 'Psychoneuroses in Peace and War and the Future of Human Relationships'. A general invitation to members of the medical profession and their friends to attend the lectures has been issued by the Salmon Committee.

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